

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Robert E ABELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-3-75</b>			2b. HOUR <b>10:55</b> M			
3. SEX <b>MALE</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 24 24</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto C. T.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Butcher's Hospital of Md.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE <b>md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13e. STREET ADDRESS <b>2129 W. Baltimore ST.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lawrence Abell</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Amanda Adamson</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Thomas Abel 3709 W. Franklin St.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Subarachnoid hemorrhage.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>14 hrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>105th</b>				
22a. I certify that (a) (this hospital) attended the deceased from <b>6-3-75 3:30</b> 19 <b>75</b> , to <b>6-3-75</b> 19 <b>75</b> , that (I) (we) lost saw the deceased alive on <b>6-3-75</b> 19 <b>75</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Sissay Awola</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>6-3-75</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sissay Awola</b>					22e. ADDRESS <b>Butcher's Hospital</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/10/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Pilgrim Ch.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Greenville Co., S.C.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H 1101 E. North Ave.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 7 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Florence Adams</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6 10 79</b>	
3 SEX <b>F</b>		4 RACE <b>W</b>		2b. HOUR <b>11:25</b> M	
5. DATE OF BIRTH MONTH DAY YEAR <b>11 26 03</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sonai</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY <b>M D Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4069 Columbia Pike</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>late Leslie Kinsey</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Katherine Cline</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214 22 1848</b>		17 INFORMANT ADDRESS <b>Mrs Virginia Arrington 2510 Pfefferkorn Road 21794</b>	
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410- <del>Unspecified</del> Acute Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Acute Leukemia, Diabetes Mellitus</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>5/17</b> 19 <b>79</b> to <b>6/10</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/10</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6/10/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James H. Piccar</b>		22e. ADDRESS <b>Sonai Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 13, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>	
23d. LOCATION CITY OR TOWN <b>Baltimore</b>		COUNTY <b>Baltimore</b>		STATE <b>Maryland</b>	
24 FUNERAL DIRECTOR <b>Harry H. Witzke 4112 Columbia Rd</b>		ADDRESS <b>Ellicott City</b>		25. DATE REGISTERED <b>JUN 13 1979</b>	
26. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13879

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Layfield William Adams, Sr</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 9 19 79</b>			2b. HOUR <b>M</b>		
3. SEX <b>male</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7-13-98</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>80</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 9 19 79</b>	2d. HOUR <b>M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1000 Wildwood Parkway</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>221 N. Fremont Ave.</b>		
14. FATHER'S NAME <b>William M. Adams</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>212-16-8566</b>		17. INFORMANT ADDRESS <b>Layfield Adams Jr. 1000 Wildwood Pwk</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular disease and cerebral</b> <b>4029</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>xx vascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Margarita A. Korell</b>		TITLE (SPECIFY) <b>Assistant</b> M.D. MEDICAL EXAMINER					DATE SIGNED <b>6/12/79</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>		ADDRESS <b>111 Penn Street, Baltimore, MD 21201</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/14/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westport, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Charles A. Rice</b> ADDRESS <b>1300 Eulan Rd</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McBrady</b>				

BP

1885

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>mabel E. Addison</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6/29/79</b>			2b. HOUR <b>7<sup>30</sup> AM</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 3 1885</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Belair Convalesorium</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Kraft</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Etta Not Known</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-24-9455A</b>		17. INFORMANT Son: <b>Joseph T. Addison</b>		ADDRESS <b>Balt., Md. 21239</b> <b>5802 A Edgepark Road</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CHRONIC RENAL FAILURE</b> (c) <b>ASCENDING</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>SENILE DEMENTIA</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY WITHIN 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>6/30/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LUN E RIVERA</b>				22e. ADDRESS <b>50 SCOTT ADAM RD, COCKEYVILLE, MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 3 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>				
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b>				ADDRESS <b>Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 2 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

BP

2737

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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Baltimore City

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Calver Park

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
<div style="display: flex; justify-content: space-between;"> <div> <p>FOR 1 - STATE REGISTRAR</p> </div> <div> <p>7 9 1 3 8 8 1</p> </div> </div>										
1. DECEASED NAME (TYPE OR PRINT) <b>MITCHELL K. AKERS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 28, 1979</b>					2b. HOUR <b>3<sup>00</sup> A.M.</b>
3. SEX <b>male</b>		4. RACE <b>CAUC.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 31 20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MIEMS</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Stone Mason-Jack</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Alexander, Inc</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Maryland Cecil Elkton</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>290 Johnstowne Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew J. AKERS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maggie Adkins</b>			17. INFORMANT ADDRESS <b>Mrs. Elizabeth J. Akers, Elkton, Md.</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>233-24-2280</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY, HEPATIC, AND RENAL FAILURE</b> 5728 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 27, 19 79</b> , to <b>JUNE 28, 19 79</b> , that (I) (we) last saw the deceased alive on <b>JUNE 28, 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Thomas R. Layton</b>				DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>JUNE 28, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS R. LAYTON, M.D.</b>				22e. ADDRESS <b>22 S. GREENE ST., BALTIMORE, MD 21201</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/2/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill Meth. Cemetery, Cherry Hill, Maryland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME <b>Donald S. Hicks</b>				25. DATE REC'D. BY REGISTRAR <b>JUL 11 1979</b>		25. REGISTRAR'S SIGNATURE <i>[Signature]</i>				
HICKS HOME for FUNERALS, ELKTON, MD.										







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1- STATE 2/16/79 Kam  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

13882

1. DECEASED NAME (TYPE OR PRINT)		FIRST Russell		MIDDLE Murray		LAST Aldrich Sr.		2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 8/1/1916		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 6 20 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wood Tool Maker		12b. KIND OF BUSINESS OR INDUSTRY Airplane			
13a. STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1916 Willow Spring Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Aldrich				15. MOTHER'S MAIDEN NAME FIRST MIDDLE Lynda Voss				21.222			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II		16b. SOCIAL SECURITY NO. 215.16.1276		17. INFORMANT ADDRESS Anna M. Aldrich--Same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUBDURAL HEMATOMA</u> 8809 Conditions, if any, which gave rise to immediate cause (a) stating the under-lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:15 PM 6/17 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) fell down steps					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Leaving bldg.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Hop's Tavern Railway Ave. Dundalk Baltimore Co., Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Hormez R. Guard				TITLE (SPECIFY) Assistant				DATE SIGNED 6/21/79			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn Street, Baltimore, MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/22/1979		23c. NAME OF CEMETERY OR CREMATORY Green Mount				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR Walter Brooks Bradley Inc. Dundalk, Md.						25a. DATE REC'D. BY REGISTRAR JUN 22 1979		25b. REGISTRAR'S SIGNATURE Pistoney McCreedy			

BP

DHMH - 17  
(V R A15 ME (51))  
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 15 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

100

7



9-1811

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 9 1 3 8 8 3 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
George		Andre	ALEXANDER	June 29 1979		12:47PM				
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE	WHITE	8 17 1943		75 YRS		MONTHS		DAYS	HOURS	MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
FRANCE	U.S.A.			Baltimore City MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore	Maryland General Hospital			CHEF		BORDIEVIEW				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
MD		BALTO		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5015 BRIARCLIFF RD				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
HIPPOLYTE		MARIE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS				
NO		215-10-4747A (JOAN) CASTEN		450 PHIBRICK CT.		CLERK BERNIE DRY				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Carcinoma Of The Esophagus</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION										
May 21, 1979										
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										
Esophageal Carcinoma with Obstruction										
20a. AUTOPSY?										
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
21b. TIME OF INJURY										
HOUR A.M. MONTH DAY YEAR										
P.M. 19										
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED										
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK										
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)										
21f. LOCATION										
STREET CITY OR TOWN COUNTY STATE										
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 18, 1979, to June 29, 1979, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on June 29, 1979, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.										
22b. SIGNATURE										
DEGREE										
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>										
22c. DATE SIGNED										
6-29-79										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										
Oussama Annous, M.D.										
22e. ADDRESS										
c/o Maryland General Hospital										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										
BURIAL										
23b. DATE										
7-3-79										
23c. NAME OF CEMETERY OR CREMATORY										
WOODLAWN CEM										
23d. LOCATION										
CITY OR TOWN COUNTY STATE										
BALTO MD										
24. FUNERAL DIRECTOR										
NAME ADDRESS										
WEBER FORERAH HOME ECHMONT										
25a. DATE REC'D. BY REGISTRAR										
JUN 2 1979										
25b. REGISTRAR'S SIGNATURE										
[Signature]										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 1 3 8 8 4	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Baby Girl Allen					2a. DATE OF DEATH MONTH DAY YEAR 5 18 79			2b. HOUR 11:40 A.M.			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 6 79		6. AGE (IN YEARS LAST BIRTHDAY) - YRS		7. IF UNDER 1 YEAR MONTHS DAYS - 12 -		8. IF UNDER 24 HRS. HOURS MIN. - -	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. CITY OR TOWN Balto					13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 108 Village Pine Crt, 21207		
14. FATHER'S NAME FIRST MIDDLE LAST Ronald Allen					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aldonia Essing						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS Ronald Allen, 108 Village Pine Court 21207				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prolapsed SGA 29.5 wks</u> <u>7640</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>DIC - Renal failure, R.D.S.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Neuro Intercerebral hemorrh.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Prolapsed - DIC -</u>											
18a. DATE OF OPERATION			18b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE Md.					
22a. I certify that (I) (this hospital) attended the deceased from <u>May 6</u> 19 <u>79</u> , to <u>May 18</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>May 18</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>E. Giangreco</u>					DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5/18/79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>E. GIANGRECO</u>					22e. ADDRESS <u>900 CATON AVE. BALTIMORE, MD. 21229</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>6/13/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEMETERY</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>4300 OLD FREDERICK RD. BALTIMORE, MD. 21229</u>			
24. FUNERAL DIRECTOR NAME <u>WITZKE OF CATONSVILLE</u>					ADDRESS <u>1630 EDMONDSON</u>		25a. DATE REC'D. BY REGISTRAR <u>5.20.1979</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

BP

8201-11





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HENRY W. ALLEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-29-79</b>			2b. HOUR <b>1:30 P</b>				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 12 17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIV. OF MD. HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LONGSHOREMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SHIPPING</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1317 COOKSIE ST.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN --- ALLEN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY --- COPPER</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>UNKNOWN</b>			16b. SOCIAL SECURITY NO. <b>214-129872</b>		17. INFORMANT ADDRESS <b>LINDA ALLEN 1400 REYNOLDS ST.</b>					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 MINS.</b>		
2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERKALEMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIABETES MELLITUS</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <b>6/29</b> 19 <b>79</b> , to <b>6/29</b> 19 <b>79</b> , that (1) (we) lost above the deceased alive on <b>6/29</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.										
22b. SIGNATURE <b>John H. Weigel</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/29/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN H. WEIGEL</b>			22e. ADDRESS <b>35 UNIV. OF MD. HOSP 22 S. GREENE ST - 220</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>7-3-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Charles L. Stevens Funeral Home, Inc.</b>					ADDRESS <b>1501 E. FULTON AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 2 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barney McBrady</b>	

6867 67







TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13886	
1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>KENNETH BYRN ALLEN</b>						2b. DATE KNOWN OF DEATH <b>6 3 1979</b>		2c. DATE OF ESTI-MATED DEATH <b>6 3 1979</b>	
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH (MONTH DAY YEAR) <b>August 13, 1949</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>29</b> YRS.	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2d. DATE PRONOUNCED DEAD <b>6 3 1979</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2617 N. Calvert St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>For National City</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>B.A.R.C.</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>—</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2617 N. Calvert St.</b>			
14. FATHER'S NAME FIRST <b>Kenneth</b> MIDDLE <b>L.</b> LAST <b>Allen</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Madelin</b> MIDDLE <b>P.</b> LAST <b>STEWART</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-58-4204</b>		17. INFORMANT <b>Howard S. Allen</b>		ADDRESS <b>1468 Reynolds St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Seizure disorder</b> <b>7803</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>—</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on <b>Autopsy</b> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Ann M. Dixon</b>				TITLE (SPECIFY) <b>Assistant</b> M.D. MEDICAL EXAMINER				DATE SIGNED <b>6-3-79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>				ADDRESS <b>111 Penn St.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-6-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Charles L. Stevens</b> ADDRESS <b>Funeral Home, Inc. 1501 E. Feather</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony M. Brady</b>			

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RECEIVED



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR		7 9 1 3 8 8 7				REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>TEMPLE C. ALLEN Sr.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6-18-79</b>			2b. HOUR <b>6:00 PM</b>		
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 7 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>74</b>		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>				12a. USUAL OCCUPATION (LIVE OR WORK FOR MOST OF WORKING LIFE) <b>Fireman Foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Amstar CO.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry C. Allen</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Young</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-09-6013</b>		17. INFORMANT ADDRESS <b>Blvd. Temple C. Allen Jr. 4018 Loch Raven</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>COPD; Bronchopneumonia</b> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Angina pectoris due</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>ASCVD</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>6-9-1979</b> , to <b>6-18-1979</b> , that (I) (we) last saw the deceased alive on <b>6-9-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>B. Narayana</b>				DEGREE <b>MD</b>			22c. DATE SIGNED <b>6-1</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. Narayana</b>				22e. ADDRESS <b>Provident Hospital Baltimore, MD-21215</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 23, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maryland Nat. Pk. Murkrk Maryland</b>			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR <b>Herbert E. Nutter</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1979</b>			25b. REGISTRAR'S SIGNATURE <i>Herbert E. Nutter</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST George	MIDDLE G.	LAST Allison	2a. DATE OF DEATH		MONTH 6	DAY 25	YEAR 79	2b. HOUR 9:00 A	MIN M				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH 3 DAY 8 YEAR 27		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.		IF UNDER 1 YEAR MONTHS OAYS		IF UNDER 24 HRS HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.											
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Md.				13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS 3210 Piedmont Ave.			
14. FATHER'S NAME FIRST Unkn MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST Queenie MIDDLE LAST				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 220-18-5191		17. INFORMANT ADDRESS Janice Witherspoon 3211 Piedmont Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest and Cardiac Arrest</i> 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis</i> DUE TO OR AS A CONSEQUENCE OF (c) <i>Chronic Alcoholism</i>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>Probable Disseminated Intravascular Coagulation</i>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>6-25</i> 19 <i>79</i> to <i>6-25</i> 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>6-25</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)																	
22b. SIGNATURE <i>Patricia Jenkins</i>				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 6-26-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA JENKINS				22e. ADDRESS 2600 LIBERTY HEIGHTS AVE BALTIMORE													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/30/79		23c. NAME OF CEMETERY OR CREMATORY King Mem. Pk.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.							
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR JUN 27 1979				25b. REGISTRAR'S SIGNATURE <i>Patricia Jenkins</i>					



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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 3 8 8 9

1. DECEASED NAME (TYPE OR PRINT) <b>Rose K. Allison</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 6, 1979</b>			2b. HOUR <b>2:07pm</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>07 22 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>71</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL</b>	
13a. STATE <b>VIRGINIA</b>			13b. CITY OR TOWN <b>WYTHEVILLE</b>		13c. STREET ADDRESS <b>1640 W. MAIN STREET</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM KIMBALL</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY REID</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>UNAVAILABLE</b>			17. INFORMANT ADDRESS <b>GRUBB FUNERAL HOME, 6th &amp; SPRING STREET</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro pulmonary Arrest</b> <b>7140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Disseminated Intravascular Coagulation</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sepsis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1d</b> <b>1d</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Rheumatoid Arthritis, Probable Pulmonary Emboli</b>									
19a. DATE OF OPERATION <b>5/25/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Rheum. Arthritis</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/5</b> 19 <b>79</b> to <b>6/6</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/6</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Paul D. Scanlon</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>6/6/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul D. Scanlon</b>				22e. ADDRESS <b>T.H.H. Baltimore Md. 21205</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL/BURIAL</b>		23b. DATE <b>06-09-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WEST END CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WYTHEVILLE WYTHE VA.</b>			
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>				ADDRESS <b>BALTO., MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony K. Brady</b>	

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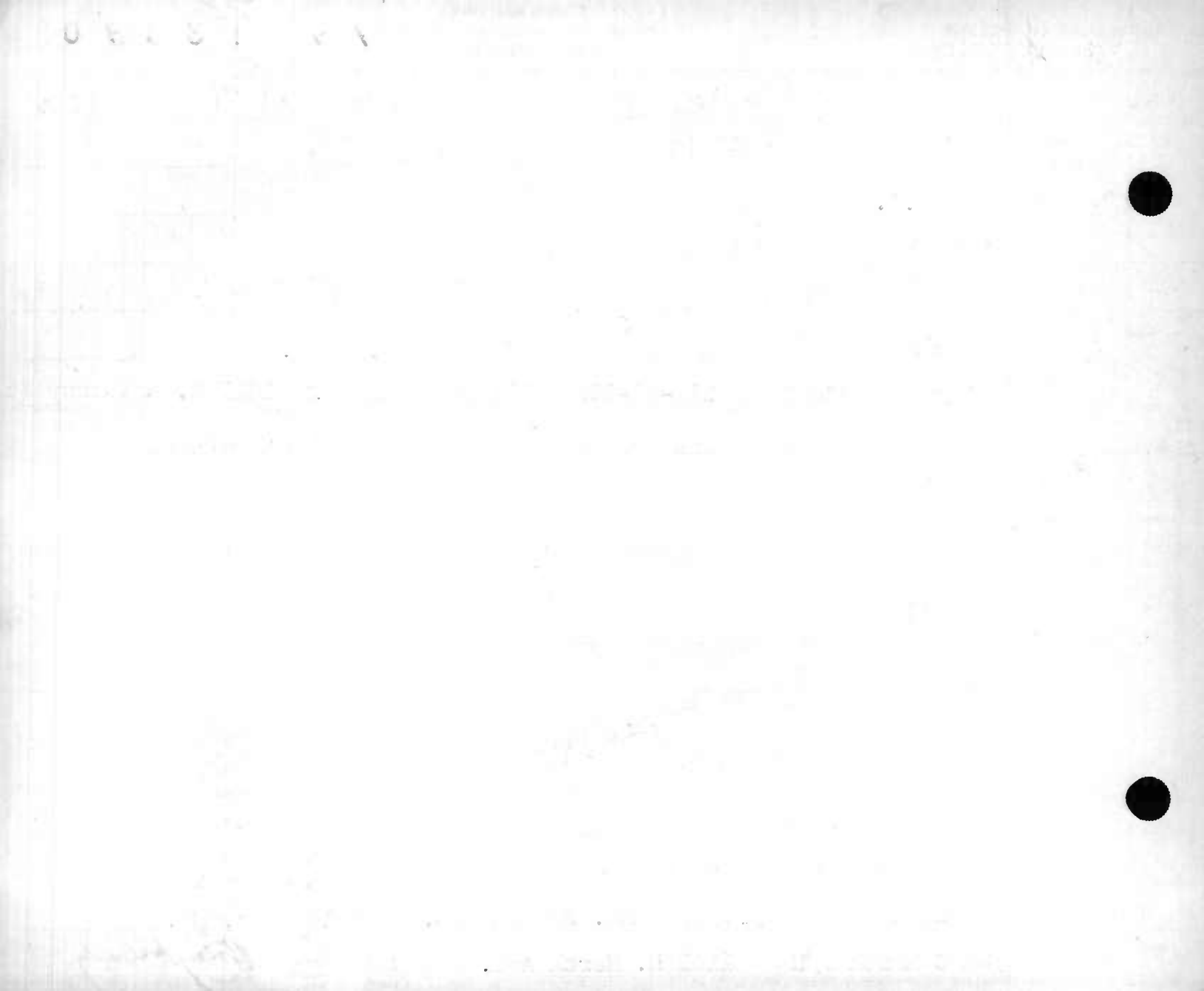


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 1 3 8 9 0			
1. FOR STATE REGISTRAR					REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <u>Alston, Claude J</u>					2a. DATE OF DEATH MONTH <u>6</u> DAY <u>22</u> YEAR <u>79</u>					2b. HOUR <u>12M</u>			
3. SEX <u>M</u>		4. RACE <u>B</u>		5. DATE OF BIRTH MONTH <u>6</u> DAY <u>24</u> YEAR <u>24</u>			6. AGE (IN YEARS LAST BIRTHDAY) <u>54</u> YRS			IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS HOURS <u></u> MIN <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>N.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>City</u> MD.						
10. CITY OR TOWN OF DEATH <u>Balt.</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>University</u>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u></u>			12b. KIND OF BUSINESS OR INDUSTRY <u></u>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <u>Md</u> 13c. COUNTY <u>Balt</u> 13d. CITY OR TOWN <u>City</u>					13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS <u>517 N. Gilman</u>						
14. FATHER'S NAME FIRST <u>Unkn</u> MIDDLE <u></u> LAST <u></u>					15. MOTHER'S MAIDEN NAME FIRST <u>Elenore</u> MIDDLE <u>Williams</u> LAST <u></u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>					16b. SOCIAL SECURITY NO <u>WWII</u>		17. INFORMANT ADDRESS <u>Elenore Williams 1417 W. Mulberry St</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent Carcinoma of the Tongue</u> <u>1460</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION <u>7/9</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u></u>			21f. LOCATION STREET <u></u> CITY OR TOWN <u></u> COUNTY <u></u> STATE <u></u>							
22. I certify that (I) (this hospital) attended the deceased from <u>6/23</u> 19 <u>79</u> to <u>6/23</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>never</u> 19 <u></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22a. SIGNATURE <u>W. Flowers MD</u>					DEGREE <u></u>			22b. DATE SIGNED <u>6/23/79</u>					
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William Flowers</u>					22d. ADDRESS <u>University Hosp.</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>6/29/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>			23d. LOCATION CITY OR TOWN <u>Baltimore</u> COUNTY <u>Md.</u> STATE <u></u>					
24. FUNERAL DIRECTOR NAME <u>Wm C March F/H</u> ADDRESS <u>1101 E. North Ave.</u>					25a. DATE REC'D. BY REGISTRAR <u>JUN 20 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Richard McCreedy</u>						



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LASSE REVIS ALSTON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-24-79</b>			2b. HOUR <b>10<sup>10</sup> P M</b>						
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4-29-1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>79</b>		8. IF UNDER 24 HRS HOURS MIN. <b>10<sup>10</sup> P M</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto City</b> MD						
10. CITY OR TOWN OF DEATH <b>Balto City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Poplar Manor Nursing H.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Va. Pub. Sch.</b>				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3512 Dennlyn Road</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Hayward A. Revis</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Louise Harrison</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>225-429519A</b>		17. INFORMANT <b>Mrs. Gloria A. Malone</b> ADDRESS <b>3512 Dennlyn Road</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST.</b> <b>4392</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>ASCVD + Hypertension</b> (c) <b>Severe Dementia</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>6-20-1979</b> to <b>6-25-1979</b> , that (I) (we) lost saw the deceased alive on <b>6-20-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Arthur G. Nutter</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6-25-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arthur G. Nutter</b>				22e. ADDRESS <b>5010 York Road BALTIMORE</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>June 30, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Family Plot</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brunswick Co. Virginia</b>				
24. FUNERAL DIRECTOR NAME <b>Herbert E. Nutter</b>				ADDRESS <b>3035 W. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>R. J. McHenry</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 01-10-2001 BY 60322

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLIE ANDERSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5-30-79</b>		2b. HOUR <b>3:20 PM</b>
3. SEX <b>M</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5-23-14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>M.D</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>4140 Reisterstown Rd. MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltim ore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>0</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>BALT</b> 13c. CITY OR TOWN <b>CITY</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>812 Regester Ave 21239</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jonah Anderson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jannie Newsom</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>0</b>		16b. SOCIAL SECURITY NO. <b>248-10-5986</b>		17. INFORMANT ADDRESS <b>Lena Signal, 4140 Reisterstwn Rd. 21215</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1919</b> IMMEDIATE CAUSE (a) <b>ASTROCYTOMA Grade III</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION <b>5/9/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4/24 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from <b>5/30</b> <b>1979</b> , to <b>5/30</b> <b>1979</b> , that (I) (we) (we) (did) saw the deceased alive on <b>5/30</b> <b>1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Jack L. Wapner</b>		DEGREE		22c. DATE SIGNED <b>5/30/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JACK L. WAPNER</b>		22e. ADDRESS <b>SINAI HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>		23b. DATE <b>6/3/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western Star Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Law Funeral Home 4611 Park Heights Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Lawyer General of the II Part of the Ave.

1913/10/10 - Letter from the General, Baltimore, Maryland

Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 10th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Your obedient servant,  
John A. [Name]

Very truly yours,  
John A. [Name]

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1913-10-10 - Letter from the General, Baltimore, Maryland

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1913-10-10 - Letter from the General, Baltimore, Maryland

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1913-10-10 - Letter from the General, Baltimore, Maryland

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DATA ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN COPIES OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13893  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR	
Marvin (W. B. Whiting) Anderson								6		23		19		79		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
male	black	3 28 26		53		YRS.				6		23		19		79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
DAWSON GA		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore City											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		17 S. Carrollton Avenue															
13a. STATE		13b. COUNTY		13c. INSIDE CITY LIMITS?		13d. EXTERIOR ADDRESS											
MD		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4023 ROMUNDSON AVE											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
FRANK WHITING		Lana Mae Rivers															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
		205-50-9953		Lana Anderson		4023 ROMUNDSON AVE											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a)		Arteriosclerotic cardiovascular disease															
4292		DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
H. R. Guard		Assistant		6/24/79													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Hormez R. Guard, M.D.		111 Penn Street, Baltimore, MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		6/25/79		Mt Airy		Baltimore		MD									
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
W. P. Hayes		JUN 27 1979		F. P. Hayes													



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>MARY</i>		FIRST <i>ANDERSON</i>		LAST		2a. DATE OF DEATH MONTH DAY YEAR <i>6-27-79</i>		2b. HOUR <i>1:22</i> P.M.	
3. SEX <i>Fem.</i>		4. RACE <i>B.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5-15-06</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S. Carol.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>BALTO.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bon Secours</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>MD</i>		13b. COUNTY		13c. CITY OR TOWN <i>BALTO.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1914 FAIR MOUNT AVE.</i>	
14. FATHER'S NAME FIRST <i>Peter</i> MIDDLE LAST <i>DAVIS</i>		15. MOTHER'S MAIDEN NAME FIRST <i>MATILDA</i> MIDDLE LAST <i>WILLIAMS</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>217-54-2416</i>		17. INFORMANT ADDRESS <i>BENE MARIE BRUNSEN 1924 W. FAIRMOUNT AVE.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC Arrest</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>MAJOR Pulm an embolism</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASEUDO - Obesity - Edema</i> Approximate interval between onset and death <i>15 min</i> <i>2h</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Reflux of liver cyst + Decub</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M.</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>6/27/79</i> 19 <i>79</i> , to <i>6-27</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>6/27</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Ch Brown</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>6/27/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARCELO F. MURRAY</i>		22e. ADDRESS <i>8548 Edgewood Rd Baltimore</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>6-30-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>WestView Mem PK</i>		23d. LOCATION CITY OR TOWN <i>Baltimore</i> COUNTY <i>MD</i> STATE <i>MD</i>			
24. FUNERAL DIRECTOR NAME <i>ISAIAH L. BROWN</i>		ADDRESS <i>4501 N. P.A.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 2 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Robert H. H. H.</i>			
1913 W. Baltimore ST.									

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 7 9 1 3 8 9 5			
1. FOR STATE REGISTRAR							
1. DECEASED NAME FIRST MIDDLE LAST <b>MAGGIE B. ARCHIE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 16, 1979</b>			
3. SEX <b>Female</b>				4. RACE <b>Black</b>			
5. DATE OF BIRTH MONTH DAY YEAR <b>6 28 13</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Balto.</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>				13b. COUNTY <b>Balto.</b>			
13c. CITY OR TOWN <b>Balto.</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS <b>2606 E. Oliver St.</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jim Archie</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ave.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>220-18-7353</b>			
17. INFORMANT <b>Joseph Lane</b>				ADDRESS <b>933 N. Patterson Pk.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>atherosclerotic cardiovascular disease</b> years DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>chronic obstructing pulmonary disease</b>							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/9</b> 19 <b>79</b> to <b>6/16</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/16</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.							
22b. SIGNATURE <b>Stephen Wank</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22c. DATE SIGNED <b>6/16/79</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen Wank</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6/20/79</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>			
25a. DATE REC'D. BY REGISTRAR <b>JUN 18 1979</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



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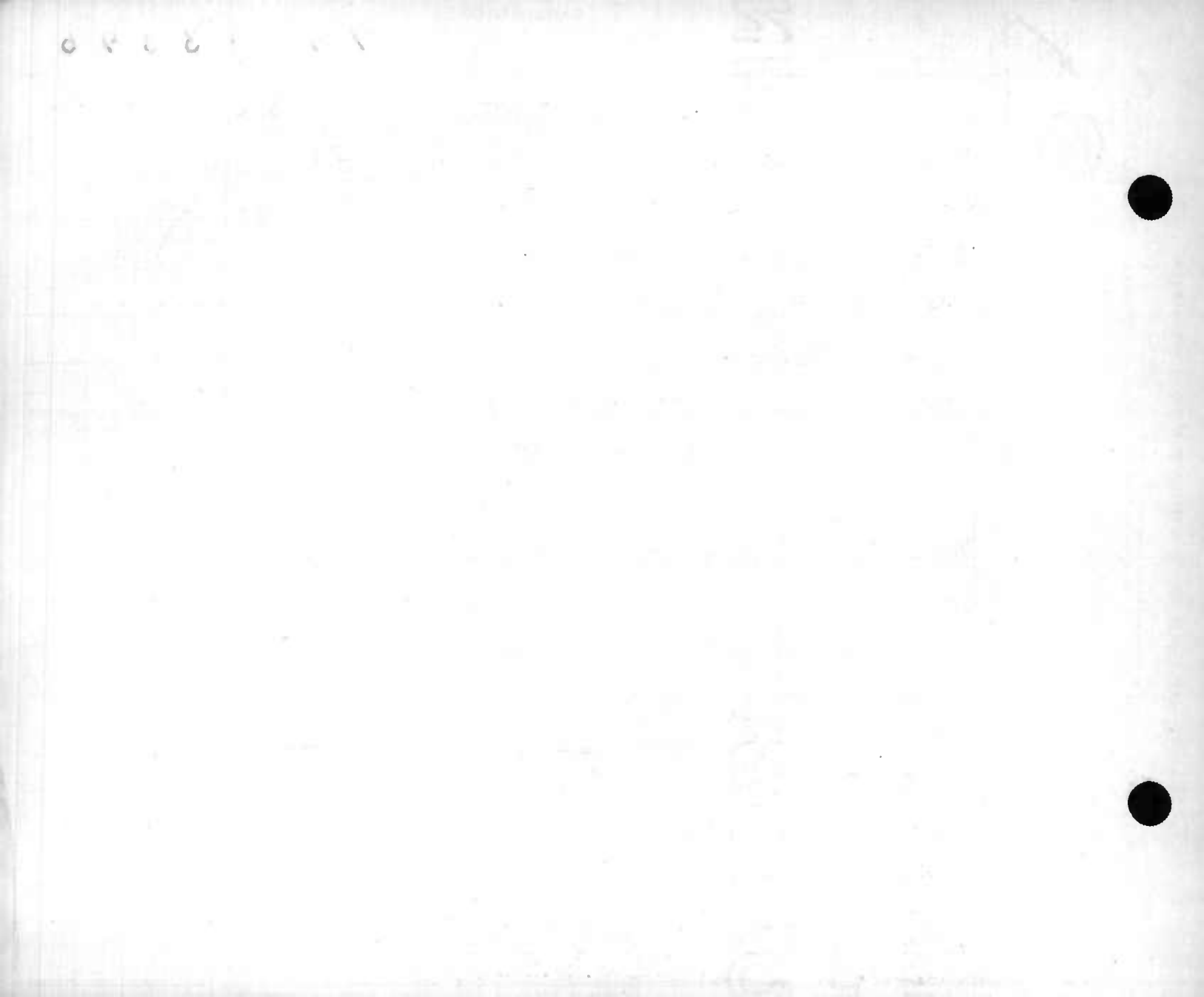
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 3 8 9 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>STANISLAUS F. ARCZYNSKI</b>				2a. DATE OF DEATH MONTH <b>June</b> DAY <b>13</b> YEAR <b>1979</b>		2b. HOUR <b>11:31 A M</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>29</b> YEAR <b>19</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balt Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>	
10. CITY OR TOWN OF DEATH <b>Balt</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Md Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Underwriter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b>Arczynski</b> LAST <b>Arczynski</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Alexandria</b> MIDDLE <b>Uziemblo</b> LAST <b>Uziemblo</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>220-03-384</b>		17. INFORMANT (NAME AND ADDRESS) <b>Lucille A. Arczynski (wife)</b> <b>Chert</b> <b>4735 Homesdale Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4/149</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial Infarction</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>June 13 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>June</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>June Baltimore, Md.</b>			
22a. I certify that (1) (this hospital) attended the deceased from <b>June 13 1979</b> to <b>June 15 1979</b> , that (1) (we) lost saw the deceased alive on <b>6/13 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Ronald J. Ross</b> DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/13/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ronald J. Ross MD</b>				22e. ADDRESS <b>University Md Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/16/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S NAME <b>St. Ignace Funeral Home, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barbara A. Brady</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 9 13897			
1. DECEASED NAME (TYPE OR PRINT) <b>SADIE M. ARMACOST</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 16, 1979</b>				2b. HOUR <b>1 P M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 28 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79 YRS</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		7. IF UNDER 24 HRS HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Hwf</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>				13b. CITY OR TOWN <b>Balto</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>1923 Drummond Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Hollie Harris</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rovilla Hare</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>217-22-0410</b>		17. INFORMANT ADDRESS <b>Mrs. Joyce A. Gray, Virginia Beach, Va.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b> <b>4279</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10-24, 1978</b> , to <b>present</b> , 19 <b>78</b> , that (I) (we) lost saw the deceased alive on <b>10-24, 1978</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6/18</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jorge H. Ordóñez-Smith MD.</b>				22e. ADDRESS <b>303 N. Rolling Rd. 21228</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6-19-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hampstead Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hampstead Carroll Md.</b>			
24. FUNERAL DIRECTOR NAME <b>ELINE FUNERAL HOME</b>				24b. ADDRESS <b>934 S. Main Street Hampstead Md. 21074</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



1903



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 3 8 9 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ALFRED R. ARNOLD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 24, 1979.</b>		2b. HOUR M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH DAY MONTH YEAR <b>July 16, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT KNOWN, GIVE STREET ADDRESS) <b>5423 Radecke Avenue</b>		12a. USUAL OCCUPATION (IF NOT KNOWN, GIVE WORKING LIFE) <b>Maintenance</b>	12b. KIND OF BUSINESS OR <b>Bethlehem Steel</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Mitchel Arnold</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ursula Borzage</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>182-16-0379</b>	17. INFORMANT ADDRESS <b>Mrs. Valera Arnold 5423 Radecke Avenue</b>		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adipose embolus (melanotic)</u> 185- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized melanotic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adipose embolus of melanotic</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8-16-77</u> <u>6-24-79</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-16-77</u> , 19 <u>77</u> , to <u>6-24</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>May 4, 1979</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Ran H. Tankin</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/27/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Louis H. Tankin MD</b>		22e. ADDRESS <b>7111 Park Heights Ave.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-27-1979</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck Inc. 5305 Harford Rd. 21214</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 28 1979</b>	25b. REGISTRAR'S SIGNATURE <u>Rafael M. Brady</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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100

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>SAMUEL J. ASBELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 5, 1979</b>			2b. HOUR <b>10:50 P M</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 1, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARried <input type="checkbox"/> NEVER MARried <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2715-F JENNER DR.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SPECIAL FED. ASSIGN.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>POST OFFICE</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>PHILIP ASBELL</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SARAH TREBOLOFF</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAY OR DATES) <b>WWII-ARMY</b>		17. INFORMANT ADDRESS <b>MRS. ROSE ASBELL 2715 -F JENNER DR. #21209</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ventricular arrhythmia</b> 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>A-S Hypertensive Ht Dis</b> (c) <b>Hypert. &amp; A-S</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 min</b> <b>5 yrs</b> <b>10 yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Diab. mellitus</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov</b> 19 <b>1977</b> to <b>May 5</b> 19 <b>79</b> , that (I) ( <del>was</del> ) lost saw the deceased alive on <b>3/16</b> 19 <b>79</b> , and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Jonas Cohen M.D.</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>May 6, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JONAS COHEN</b>		22e. ADDRESS <b>6702 PARK HEIGHTS AVE 21215</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>MAY 7, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHIZUK AMONO</b>		23d. LOCATION <b>BALTIMORE</b> COUNTY <b>MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Crowley</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

9 2 5 8 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

13900

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BARBARA</b>			FIRST <b>ASHENDEN</b>			LAST <b>ASHENDEN</b>			2a. DATE OF DEATH MONTH <b>JUNE</b>			DAY <b>26,</b>			YEAR <b>1979</b>			2b. HOUR <b>8:30 AM</b>																	
3 SEX <b>FEMALE</b>			4. RACE <b>BLACK</b>			5. DATE OF BIRTH MONTH <b>7</b>			DAY <b>22</b>			YEAR <b>1900</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.			IF UNDER 1 YEAR MONTHS <b>0</b>			IF UNDER 24 HRS DAYS <b>0</b>			HOURS <b>0</b>			MIN <b>0</b>								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE</b>			7b. CITIZEN OF WHAT COUNTRY? <b>THE UNITED STATES OF AMERICA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.																										
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>						13b. COUNTY <b>BALTIMORE</b>						13c. CITY OR TOWN <b>BALTIMORE</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>2203 SOUTH ROAD</b>														
14. FATHER'S NAME FIRST <b>UNK.</b>						MIDDLE <b>UNK.</b>						LAST <b>UNK.</b>						15. MOTHER'S MAIDEN NAME FIRST <b>UNK.</b>						MIDDLE <b>UNK.</b>						LAST <b>UNK.</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS																							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CAR CINO MATUS Meningitis</b> <b>1749</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Breast Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (this hospital) attended the deceased from <b>6/1/79</b> , 19 <b>79</b> , to <b>6/26</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/26</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <b>J.P. Peters</b>				DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>6/26/79</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J.P. Peters</b>				22e. ADDRESS <b>Johns Hopkins Hospital</b>															

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>				23b. DATE <b>6/27/79</b>				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>								ADDRESS <b>Balto., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 3 1979</b>				25b. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>			

BP



6/27/72

Removal

Section, No.

Analysis Board



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13901  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST CHARLES		MIDDLE		LAST AVERY		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 6		DAY 19		YEAR 1979		2b. HOUR 5:54			
3. SEX male		4. RACE negro		5. DATE OF BIRTH MONTH DAY YEAR 3 10 23		6. AGE (IN YEARS) (LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 19 1979		2d. HOUR 5:54					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Charleston SC				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City				MD			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1214 Argyle Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE MD				13b. COUNTY Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 1214 Argyle Ave							
14. FATHER'S NAME FIRST MIDDLE LAST John Henry				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 217-07-5781				17. INFORMANT ADDRESS John Henry 3439 PK Heights Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4280 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Ann M. Dixon, M.D.				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 6-19-79							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL (CITY)				23b. DATE 6/22/79				23c. NAME OF CEMETERY OR CREMATORY Mt Airy				23d. LOCATION (CITY OR TOWN) COUNTY STATE Baltimore MD							
24. FUNERAL DIRECTOR Name Wm P. Hayes 6384 C. Im on St								25a. DATE REC'D. BY REGISTRAR JUN 21 1979				25b. REGISTRAR'S SIGNATURE P. Hayes							

BP

10001



*[Faint, illegible handwritten text]*

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
IVR A15 ME (5)  
15M 7/76

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13902

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		7b. HOUR	
Edward RALPH Babst								<input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>		6		12		19 79		M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR 3:03A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
NEW JERSEY		USA				Baltimore City, MD.											
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHARMACIST		12b. KIND OF BUSINESS OR INDUSTRY DRUGS											
13a. STATE MARYLAND		13b. COUNTY Balt		13c. CITY OR TOWN MONKTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 15800 CARROLL RD. #21111									
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES SOL BABST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAY CAMMERMAN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WWII-NAVY 156-07-2842		17. INFORMANT MRS. REBA BABST		15800 CARROLL RD., MONKTON, MD 21111							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Thermal and inhalation injury with complications Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 8150 (b). (c).		DUE TO, OR AS A CONSEQUENCE OF				DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOURS MONTH DAY YEAR 10:30 A.M. 6 3 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/fixed object with fire													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Sparks Rd. Balto. MD													
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 6/12/79													
ACTUAL SIGNATURE 		EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St. Balto., MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUNE 13, 1979		23c. NAME OF CEMETERY OR CREMATORY HAR SINAI		23d. LOCATION CITY OR TOWN COUNTY STATE ONINGS MILLS BALTO. MD											
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.		ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR JUN 14 1979		25b. REGISTRAR'S SIGNATURE 											

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 13903	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
		HARWOOD R. BAGBY				6 28 79		7-10 P			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS	
Male		White		June 30, 1902		76 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		USA				BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		UNION MEMORIAL HOSPITAL		Executive		Furniture Co.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3601 Greenway			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
William F. Bagby		Virginia Bagby									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS					
No		213 05 8300		Mrs. Lillian W. Bagby		Same					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 496- C. D. P. D. DUE TO, OR AS A CONSEQUENCE OF (b) prostate Ca. & Metastasis DUE TO, OR AS A CONSEQUENCE OF (c) 10 yrs. 3 yrs.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6/26 19 79 to 6/28 19 79, that (I) (we) lost saw the deceased alive on 6/28 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
H. W. Chen		M.D.						6/28/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
H. W. CHEN-GIEK		Union Memorial Hosp. Baltimore									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		7-2-79		Loudon Park		Baltimore, Md.					
24. FUNERAL DIRECTOR NAME		24b. ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Henry W. Jenkins & Sons Co.		4905 York Road Balto., Md. 21212				JUL 3 1979		R. J. McCreedy			

20121

14

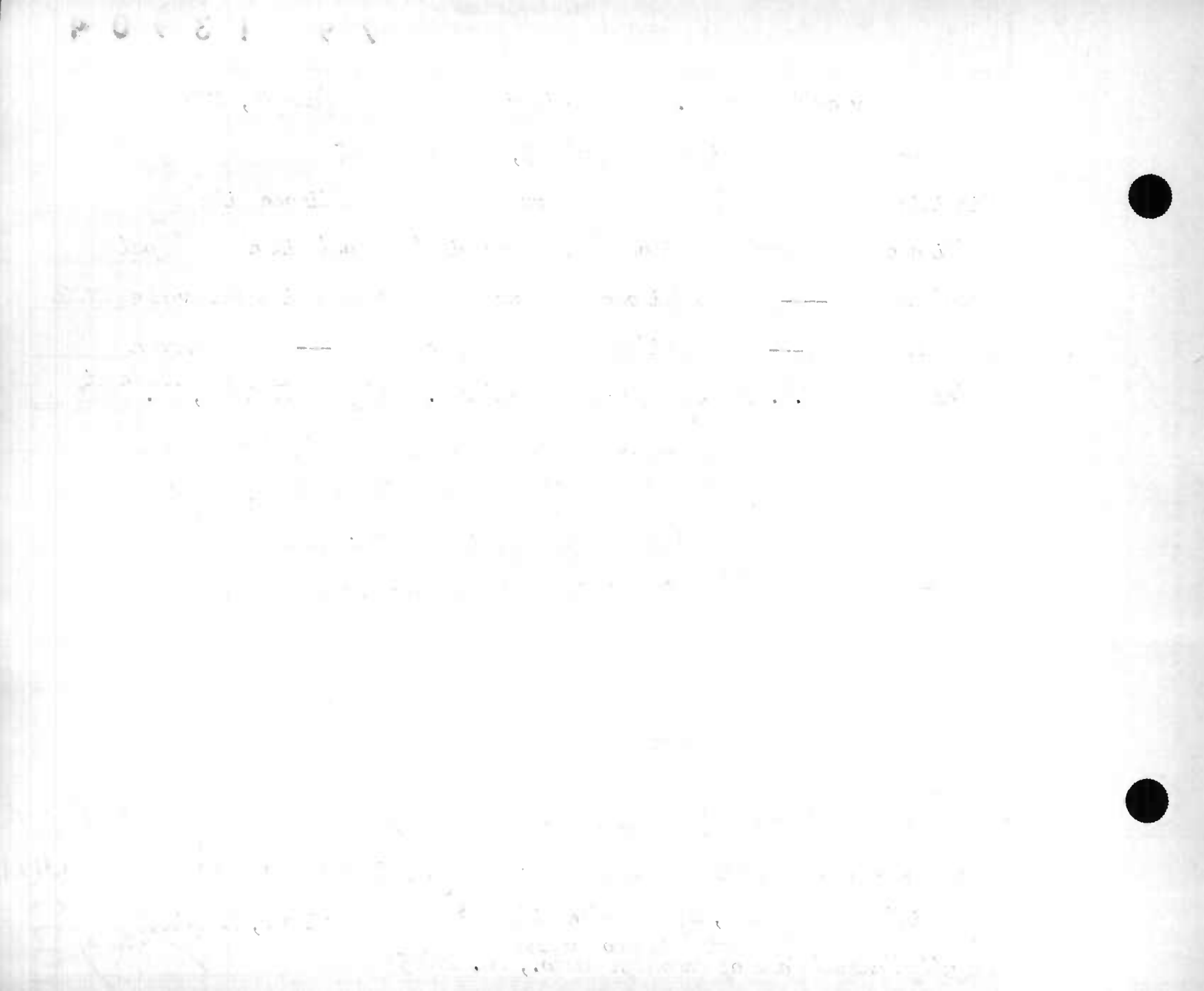
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
1- FOR STATE REGISTRAR		7 9 1 3 9 0 4 CERTIFICATE OF DEATH									
1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR
Everett		R.	Bailey	June 14, 1979						M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male	White	MONTH DAY YEAR July 27, 1971		67		MONTHS DAYS		HOURS MIN			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
Virginia	USA			Baltimore City MD.							
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
Baltimore	South Baltimore General Hospital			Coal Miner			Coal				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS					
Maryland				Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3902 Fairhaven Avenue 21226					
14 FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
John				Bailey	Emer				Unknown		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS					
Yes		W.W. 2		227 09 0196		Charles M. Bailey 1646 Popland Street Baltimore, Md. 21226					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Massive myocardial infarction											
410- DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Atherosclerotic cardiovascular disease											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Generalized arteriosclerosis											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
Bronchial asthma, chronic. Hypertension. Isthm etc.											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		DEGREE					22c DATE SIGNED				
Nick P. Moutsos		M.D.					6/18/79				
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
Nick P. Moutsos, M.D.		950 Quabart Rd Glen Burnie Md 21061									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		June 18, 1979		Cedar Hill Cemetery		Baltimore, Maryland					
24 FUNERAL DIRECTOR NAME		24b ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
McCully Funeral Home of Brooklyn Balto., Md.		237 East Patapsco Avenue		JUN 18 1979		[Signature]					





FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

13905

1. DECEASED NAME (TYPE OR PRINT) <b>Harry L. Bailey</b>			2a. DATE OF DEATH KNOWN ESTI- MATED <input checked="" type="checkbox"/> <b>6 29 1979</b>			2b. HOUR <b>3:10</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 8 32 47</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>47</b> YRS.	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN <b>0 0</b>	2c. DATE PRONOUNCED DEAD <b>6 29 1979</b>		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Stripper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Printing Co.</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Edgemere</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Lohr</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Glennia M. Crawford</b>			13e. STREET ADDRESS <b>2505 Eugene Avenue</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>217-26-9837</b>		17. INFORMANT <b>Suzane M. Bailey</b>		ADDRESS <b>2505 Eugene Ave. Balto. MD 21219</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. <b>Healed aortic valvulitis</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>			TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>6/29/79</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>			ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/2/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Baltimore, MD</b>		
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 3 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		
ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>								

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

CU 161 87



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



*[Handwritten signature]*



FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

13907

1. DECEASED NAME (TYPE OR PRINT) <b>Shirley</b>		FIRST <b>Shirley</b>		MIDDLE		LAST <b>Ball</b>		2a. DATE OF DEATH MONTH <b>6</b> DAY <b>23</b> YEAR <b>79</b>				2b. HOUR <b>7:55P</b> M			
3 SEX <b>F</b>		4 RACE <b>B</b>		5. DATE OF BIRTH MONTH <b>6</b> DAY <b>-2-</b> YEAR <b>27</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS				IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO, Md</b> CITY <b>CITY</b> MD.							
10 CITY OR TOWN OF DEATH <b>Md</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hosp.</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DOMESTIC</b>				12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>802 WOODINGTON Rd</b>							
14 FATHER'S NAME FIRST <b>LEONARD</b> MIDDLE <b></b> LAST <b>CALAMAN</b>		15. MOTHER'S MAIDEN NAME FIRST <b>GRACE</b> MIDDLE <b></b> LAST <b>CAREY</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b></b>		17. INFORMANT ADDRESS <b>STUART CALAMAN 4523 HOMER AVE.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4275</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> (c) <b></b> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cirrhosis</b>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <b>6-23</b> , 19 <b>79</b> , to <b>6-23</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6-23</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <b>Dr. HANIF</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K HANIF MD</b>		22e. ADDRESS <b>Lutheran Hosp.</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-27-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. NAT. Mem PK.</b>		23d. LOCATION CITY OR TOWN <b>LAUREL</b> COUNTY <b>Md</b> STATE <b>Md</b>									
24 FUNERAL DIRECTOR NAME <b>James A Morton sons</b>		ADDRESS <b>1701 Laurens</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10001





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

13908

1. DECEASED NAME (TYPE OR PRINT) GUS BANKS			2a. DATE OF DEATH MONTH DAY YEAR 6 5 79			2b. HOUR 4 45 P.M.	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 10-10-1899		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD.	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTEBELLO HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charlie Banks		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) ---0--- (IF YES, GIVE WAR OR DATES) ---0---		16b. SOCIAL SECURITY NO. 042-01-7613		17. INFORMANT ADDRESS Sallie Banks, 1418 Poplar Grove Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Hypertensive Arteriosclerotic C.V.D.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4.5 m.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Cerebrovascular Accident &amp; Hemiplegia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-16-79</u> , 19 <u>79</u> , to <u>6-5</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-5</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Elisa M. Goris M.D.		DEGREE MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-5-1979			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELSA M. GORIS		22e. ADDRESS MONTEBELLO HOSPITAL 2201 ARGOWE DR. BALTO MD 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/9/79		23c. NAME OF CEMETERY OR CREMATORY Deer Pk Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Law Funeral Home 4611 Park Heights Ave.				25a. DATE REC'D. BY REGISTRAR JUN 11 1979		25b. REGISTRAR'S SIGNATURE Anthony M. Brady	

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Charlie

-----0-1-13 Bellie Lane, 161 Solar Grove Street

1. The General of the High Court of the State of New York, in and for the County of New York, do hereby certify that the within and foregoing is a true and correct copy of the original of the same, as the same appears from the records of the said Court.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13909

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		6		9		11:58	
Vander		L.		Bannister									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD	
Male		Black		1 6 43		36 YRS.		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH	
S.C.		USA										Baltimore City, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		University Hospital (STU)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		420 N. Loudon Ave.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Elijah		Emma		Bannister		Anderson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		Vietnam		Azalee Gibson		420 N. Loudon Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Gunsight wound to thorax and abdomen with com- plications		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
9654		DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF									
		(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
		2:25xx 4 17 19 79		Subject shot by unknown assailant									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
		street		Calverton Rd., Baltimore						Md.			
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		M.D.		TITLE (SPECIFY)		DATE SIGNED							
Margarita A. Korell, M.D.		Assistant		MEDICAL EXAMINER		6/10/79							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		6/14/79		King Mem. Pk.		Baltimore Co., Md.							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Wm C March F/H		JUN 12 1979		1101 E. North Ave.									

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Items #18--22a--22b--22c--22d--22e--22f--22g--22h--22i--22j--22k--22l--22m--22n--22o--22p--22q--22r--22s--22t--22u--22v--22w--22x--22y--22z--23--24--25--26--27--28--29--30--31--32--33--34--35--36--37--38--39--40--41--42--43--44--45--46--47--48--49--50--51--52--53--54--55--56--57--58--59--60--61--62--63--64--65--66--67--68--69--70--71--72--73--74--75--76--77--78--79--80--81--82--83--84--85--86--87--88--89--90--91--92--93--94--95--96--97--98--99--100--101--102--103--104--105--106--107--108--109--110--111--112--113--114--115--116--117--118--119--120--121--122--123--124--125--126--127--128--129--130--131--132--133--134--135--136--137--138--139--140--141--142--143--144--145--146--147--148--149--150--151--152--153--154--155--156--157--158--159--160--161--162--163--164--165--166--167--168--169--170--171--172--173--174--175--176--177--178--179--180--181--182--183--184--185--186--187--188--189--190--191--192--193--194--195--196--197--198--199--200--201--202--203--204--205--206--207--208--209--210--211--212--213--214--215--216--217--218--219--220--221--222--223--224--225--226--227--228--229--230--231--232--233--234--235--236--237--238--239--240--241--242--243--244--245--246--247--248--249--250--251--252--253--254--255--256--257--258--259--260--261--262--263--264--265--266--267--268--269--270--271--272--273--274--275--276--277--278--279--280--281--282--283--284--285--286--287--288--289--290--291--292--293--294--295--296--297--298--299--300--301--302--303--304--305--306--307--308--309--310--311--312--313--314--315--316--317--318--319--320--321--322--323--324--325--326--327--328--329--330--331--332--333--334--335--336--337--338--339--340--341--342--343--344--345--346--347--348--349--350--351--352--353--354--355--356--357--358--359--360--361--362--363--364--365--366--367--368--369--370--371--372--373--374--375--376--377--378--379--380--381--382--383--384--385--386--387--388--389--390--391--392--393--394--395--396--397--398--399--400--401--402--403--404--405--406--407--408--409--410--411--412--413--414--415--416--417--418--419--420--421--422--423--424--425--426--427--428--429--430--431--432--433--434--435--436--437--438--439--440--441--442--443--444--445--446--447--448--449--450--451--452--453--454--455--456--457--458--459--460--461--462--463--464--465--466--467--468--469--470--471--472--473--474--475--476--477--478--479--480--481--482--483--484--485--486--487--488--489--490--491--492--493--494--495--496--497--498--499--500--501--502--503--504--505--506--507--508--509--510--511--512--513--514--515--516--517--518--519--520--521--522--523--524--525--526--527--528--529--530--531--532--533--534--535--536--537--538--539--540--541--542--543--544--545--546--547--548--549--550--551--552--553--554--555--556--557--558--559--560--561--562--563--564--565--566--567--568--569--570--571--572--573--574--575--576--577--578--579--580--581--582--583--584--585--586--587--588--589--590--591--592--593--594--595--596--597--598--599--600--601--602--603--604--605--606--607--608--609--610--611--612--613--614--615--616--617--618--619--620--621--622--623--624--625--626--627--628--629--630--631--632--633--634--635--636--637--638--639--640--641--642--643--644--645--646--647--648--649--650--651--652--653--654--655--656--657--658--659--660--661--662--663--664--665--666--667--668--669--670--671--672--673--674--675--676--677--678--679--680--681--682--683--684--685--686--687--688--689--690--691--692--693--694--695--696--697--698--699--700--701--702--703--704--705--706--707--708--709--710--711--712--713--714--715--716--717--718--719--720--721--722--723--724--725--726--727--728--729--730--731--732--733--734--735--736--737--738--739--740--741--742--743--744--745--746--747--748--749--750--751--752--753--754--755--756--757--758--759--760--761--762--763--764--765--766--767--768--769--770--771--772--773--774--775--776--777--778--779--780--781--782--783--784--785--786--787--788--789--790--791--792--793--794--795--796--797--798--799--800--801--802--803--804--805--806--807--808--809--810--811--812--813--814--815--816--817--818--819--820--821--822--823--824--825--826--827--828--829--830--831--832--833--834--835--836--837--838--839--840--841--842--843--844--845--846--847--848--849--850--851--852--853--854--855--856--857--858--859--860--861--862--863--864--865--866--867--868--869--870--871--872--873--874--875--876--877--878--879--880--881--882--883--884--885--886--887--888--889--890--891--892--893--894--895--896--897--898--899--900--901--902--903--904--905--906--907--908--909--910--911--912--913--914--915--916--917--918--919--920--921--922--923--924--925--926--927--928--929--930--931--932--933--934--935--936--937--938--939--940--941--942--943--944--945--946--947--948--949--950--951--952--953--954--955--956--957--958--959--960--961--962--963--964--965--966--967--968--969--970--971--972--973--974--975--976--977--978--979--980--981--982--983--984--985--986--987--988--989--990--991--992--993--994--995--996--997--998--999--1000

13910  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Yvonne		MIDDLE L.		LAST Barber		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 6		DAY 8		YEAR 1979		2b. HOUR M 8:10 A			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 28 56		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 22		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 8 1979		2d. HOUR M 8:10 A					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.				13b. COUNTY				13c. CITY OR TOWN Balto.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS			
14. FATHER'S NAME FIRST MIDDLE LAST John Thomas Barber				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Thorpe															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)				17. INFORMANT ADDRESS Mary Barber 1354 Homestead St.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> 986- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Multiple vaginal and rectal lacerations</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:44 6/8/ 1979				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Unknown											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) grassy area				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2200 Block of Tucker La. Baltimore Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> .																			
ACTUAL SIGNATURE Virginia L. Dolan MD				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								DATE SIGNED 6/8/79							
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/14/79				23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk.				23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Md.							
24. FUNERAL DIRECTOR NAME Wm C March F/H								ADDRESS 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR JUN 12 1979				25b. REGISTRAR'S SIGNATURE Dorothy McBrady			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 11 02.

FOR 1 - STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 3 9 1 1																																							
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH										2b. HOUR																																							
FIRST MIDDLE LAST										MONTH DAY YEAR										M																																							
JENNINGS Leroy BARNES										JUNE 7, 1979										4:00A																																							
3 SEX										4 RACE										5 DATE OF BIRTH										6 AGE (IN YEARS LAST BIRTHDAY)										7 IF UNDER 1 YEAR										8 IF UNDER 24 HRS									
Male										Black										11 4 1917										61 60										MONTHS DAYS HOURS MIN.																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 BALTIMORE CITY OR COUNTY OF DEATH										MD.																			
Md.										USA																				BALTIMORE CITY																													
10 CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																													
Balto.										THE JOHNS HOPKINS HOSPITAL																																																	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. INSIDE CITY LIMITS?										13b. STREET ADDRESS																																							
13a. STATE										13b. CITY OR TOWN										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										1509 E. Federal St.																													
14 FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
FIRST MIDDLE LAST										FIRST MIDDLE LAST																																																	
Unkn Earnest Barnes										Unkn Edith Anderson																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17 INFORMANT										ADDRESS																													
Yes										WWII										Essie Barnes										1914 N. Fulton Ave.																													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY										IMMEDIATE CAUSE (a)										1 hour																																							
5711										Respiratory Arrest																																																	
DUE TO, OR AS A CONSEQUENCE OF										membrane damage										> 5 days																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF										?																																							
(b)										Severe Alcoholic Hepatitis																																																	
(c)																																																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																													
																				YES <input type="checkbox"/> NO <input type="checkbox"/>										YES <input type="checkbox"/> NO <input type="checkbox"/>																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																																							
										HOUR A.M. MONTH DAY YEAR																																																	
										P.M.																																																	
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)										21f. LOCATION																																							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																				STREET										CITY OR TOWN COUNTY STATE																													
22a. I certify that (I) (this hospital) attended the deceased from 6/2, 19 79, to 6/7, 19 79, that (I) (was) last saw the deceased alive on 6/7, 19 79, and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE										DEGREE										22c. DATE SIGNED																													
										MD										ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>										6/7/79																													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS																																																	
ALLEN ACIUFFO																																																											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION																													
Burial										6/12/79										Baltimore Cemetery										CITY OR TOWN COUNTY STATE																													
																				Westview Mem. Pk.										Catonsville, Md.																													
24 FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																							
NAME										ADDRESS										JUN 1 1979										Fitzroy Kennedy																													
Wm C March F/H										1101 E. North Ave.																																																	



11001

8-1-81



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CECELIA ECCELIA</b>		FIRST <b>CECELIA</b> MIDDLE <b>ECCELIA</b> LAST <b>BARNSTEIN</b>		2a. DATE OF DEATH MONTH <b>6</b> DAY <b>7</b> YEAR <b>79</b>		2b. HOUR <b>9:35</b> M	
3. SEX <b>F</b> FEMALE		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH <b>1</b> DAY <b>10</b> YEAR <b>22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>	
14. FATHER'S NAME FIRST <b>ISAAC</b> MIDDLE <b>SCHERR</b> LAST <b>SCHERR</b>		15. MOTHER'S MAIDEN NAME FIRST <b>FANNIE</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-18-6614</b>		17. INFORMANT <b>MR. FRED BARNSTEIN</b> ADDRESS <b>5611 NORTHGREEN RD. 21207</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PROBABLE PULMONARY EMBOLUS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PARADOXIC PULMONARY EMBOLUS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HEART DISEASE</b> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 MINUTES</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5/19 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5/19 1979</b> to <b>6/7 1979</b> , that (I) (we) lost saw the deceased alive on <b>NEVER</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.							
22b. SIGNATURE <b>William S. Wood</b> MD		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/7/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM S WOOD</b>		22e. ADDRESS <b>SINAI HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6-10-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ANSHE EMUNAH</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>	
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> NAME ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 13 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 3 9 1 3									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Baby Boy						Bartlett		June 8 1979		1 PM M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS	
Male		White		MONTH DAY YEAR		6 8 79		YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
						Baltimore City MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Mercy									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 7650 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Extreme prematurity (16 wks by date) 240 gms.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>date</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:55 P.M. 6 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) MERCY HOSPITAL		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4:55am 6/8, 1979, to 1:00pm 6/8, 1979, that (I) (we) lost the deceased alive on 6/8, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>S. Tonides</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/9/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Tonides		22e. ADDRESS MERCY HOSPITAL									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 6/14/79		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board						ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JUN 20 1979		25b. REGISTRAR'S SIGNATURE R. McCreedy	

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(M)

(55)

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 13914

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		FIRST MOLLIE		MIDDLE BAUMEL		LAST 6 23 79 1:30 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 8 DAY 10 YEAR 09		6. AGE (IN YEARS (LAST BIRTHDAY)) 69 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST ABRAHAM		15. MOTHER'S MAIDEN NAME FIRST SARAH		13e. STREET ADDRESS 7 SLADE AVE., APT. 210 #21208			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-52-5134		17. INFORMANT ADDRESS MILTON BAUMEL 7 SLADE AVE., APT. 210 #21208			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) metastatic carcinoma one year PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/13, 19 79 to 6/23, 19 79, that (I) (we) last saw the deceased alive on 6/23, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert A. Wacks		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/23/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A. Wacks		22e. ADDRESS Sinai Hosp. of Balt.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-24-79		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH CONG.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215				25a. DATE REG'D BY REGISTRAR JUN 27 1979		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

13914





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13915	
1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joshua Beasley Sr.										2b. DATE KNOWN OF DEATH ESTI-MATED MONTH DAY YEAR 6 30 19 79	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 24 25		6. AGE (IN YEARS (LAST BIRTHDAY)) 54 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 30 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffeur		12b. KIND OF BUSINESS OR INDUSTRY TRASH			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 55 D. Morley St.			
14. FATHER'S NAME FIRST MIDDLE LAST WALTER BEASLEY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CORA ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. R18-12-4253		17. INFORMANT ADDRESS NELLIE BEASLEY 141 N. PULVER ST					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease											
4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from <input checked="" type="checkbox"/> Natural Causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 6/30/79			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/6/79		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE A.P. County, Md.					
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Locks FUNERAL HOME 1304 N. Bata				JUL 3 1979		Ritney McBrady					

DATE  
DELETED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Frank D. Beck</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>June 27, 1979</i>		2b. HOUR M	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 25, 1901</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Balto. Md.</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) <i>6006 Plumber Ave. - 21206</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Pipe Fitter</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Coast Guard</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. STREET ADDRESS <i>6006 Plumber Ave.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Deweese Beck</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Clara Wills</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>216-03-6839</i>		17. INFORMANT ADDRESS <i>Mrs. Adele W. Beck - 6006 Plumber Ave. - 21206</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Lung</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>ABCD</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>3-2</i> 19 <i>56</i> to <i>6-27</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>5-22</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>6-28-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>WYMAN K. WONG M.D.</i>		22e. ADDRESS <i>6801 Belair Rd 21206</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6-30-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cem.</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>					
24. FUNERAL DIRECTOR NAME <i>John C. Miller Inc-6415 Belair Rd. - 21206</i>		ADDRESS		25a. D.B. REC'D. BY REG. CLERK <i>JUL 2 1979</i>	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



Rank 1. Recd

June 27, 1979

date

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FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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1. DECEASED NAME (TYPE OR PRINT) <b>ETHEL G. BEEBE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 26 79</b>			2b. HOUR <b>1:20 AM</b>			
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct 18, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7c. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md</b>			13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Bell</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Amanda Gosnell</b>			16. STREET ADDRESS <b>281 W. 31st Street</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>213 52 6987</b>		17. INFORMANT ADDRESS <b>Clarence Beebe 7227 Morgan Rd Woodbine</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>GI. BLEED.</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>6/15</b> , 19 <b>79</b> , to <b>6/26</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/26</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>James D. Gallant MD</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/26/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES D GALLANT</b>			22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/28/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Balto. Md</b>		
24. FUNERAL DIRECTOR NAME <b>Burgee Funeral Home</b>			ADDRESS <b>3631 Falls Road 21211</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Items #10a-22a Film G533 7/16/79 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13918  
 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Delores Bell</b>				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 20 19 79</b>				2b. HOUR M <b>9:40</b> P.M.	
3. SEX <b>female</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 4 38</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>41</b>	IF UNDER 1 YR. MONTHS DAYS <b>41</b>	IF UNDER 24 HRS. HOURS MIN <b>41</b>	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 20 19 79</b>		7d. HOUR M <b>9:40</b> P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SERVICE STATION</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CASHIER</b>	
13a. STATE <b>md</b>				13b. COUNTY <b>BALTO.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>1741 E. 35th ST</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>BERNARD BROWN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA MAE MORGAN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>214-54-4064</b>		17. INFORMANT ADDRESS <b>IDA MAE BENNETT 2900 Poplar Dr.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of head (Handgun)</b> <b>9550</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>? P.M. 6/20/19 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>shot self</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1741 E. 35th St. Baltimore Maryland</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>JRS Shaw</b>				TITLE (SPECIFY) <b>Assistant</b>		MEDICAL EXAMINER		DATE SIGNED <b>6/21/79</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn Street, Balto., MD 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6/23/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem PK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. County MD</b>	
24. FUNERAL DIRECTOR NAME <b>LOCKE FUNERAL HOME</b>				ADDRESS <b>1304 N. Central</b>		25a. DATE RECEIVED BY REGISTRAR <b>JUN 27 1979</b>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE THIS CERTIFICATE WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201. IF ANY DELAY IS NECESSARY, FILE THIS CERTIFICATE WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201. IF ANY DELAY IS NECESSARY, FILE THIS CERTIFICATE WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 13919	
1. FOR STATE REGISTRAR						
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUELLA M. BELL			2a. DATE OF DEATH MONTH DAY YEAR 6 7 79		2b. HOUR 7:02 <sup>A</sup> M	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 3 8 13		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY 13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 929 McDonogh St.	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bonnie Platt				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-01-2409		17. INFORMANT ADDRESS Bertha M. Bell 929 McDonogh St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest.</u> 2050 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis, Aplasia.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Myelogenous Leukemia.</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>5/11</u> , 19 <u>79</u> , to <u>6/7</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/7</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Frank L. Douglas</u>				DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>6/7/79</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank L. Douglas				22e. ADDRESS Johns Hopkins Hosp. & C., Dept. Medicine		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/11/79		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 8 1979
						25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					79 13920 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>ROSCOE - BELL</b>					2a. DATE OF DEATH MONTH <b>06</b> DAY <b>14</b> YEAR <b>79</b>				
3 SEX <b>MALE</b>		4 RACE <b>BLACK</b>		5 DATE OF BIRTH MONTH <b>04</b> DAY <b>09</b> YEAR <b>07</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		7b. HOUR <b>1:15 P.M.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montebello Hospital of Baltimore</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>222 CAREY ST.</b>	
14. FATHER'S NAME FIRST <b>HARVEY</b> MIDDLE <b>BELL</b> LAST <b>BELL</b>				15. MOTHER'S MAIDEN NAME FIRST <b>BERTHA</b> MIDDLE <b>RICHARDSON</b> LAST <b>RICHARDSON</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT <b>MARY E. BELL</b>		ADDRESS <b>222 CAREY ST.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>3320</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Parkinson's Disease</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>minute</b> <b>Yrs.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Paraplegia 2° to polyneuropathy, Post flap surgery for sacral ulcer</b>									
19a. DATE OF OPERATION <b>6, 8, 79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Sacral ulcer - flap surgery</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>05-10</b> 19 <b>71</b> , to <b>06-14</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>06-14-</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Khosrow Esna</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>6, 14, 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KHOSROW ESNA</b>				22e. ADDRESS <b>Montebello Hospital</b> <b>2201 Argonne Dr. Baltimore, Md. 21218</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6-20-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>L.H. CALVARY CEM.</b>		23d. LOCATION CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b> STATE			
24 FUNERAL DIRECTOR NAME <b>VERNON R. BAILEY</b> ADDRESS <b>1348 Calhoun St.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert K. Bailey</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - FOR STATE REGISTRAR										
1 DECEASED NAME FIRST MIDDLE LAST HARRY W BELSCHNER, Jr.					2a. DATE OF DEATH MONTH DAY YEAR 6 22 79.					
3 SEX M					4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 3 7 1908		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10 CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sheet Metal Wkr		12b KIND OF BUSINESS OR INDUSTRY Roof Const.	
13a STATE Md					13b COUNTY -	13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Harry Belschner					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie Flowman					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217 01 0359		17 INFORMANT Edith Belschner		ADDRESS Same			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① VENTRICULAR STANDSTILL, pul. embolism ② 4292 } DUE TO, OR AS A CONSEQUENCE OF asperation (b) ② A.S.C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (c) ③ COR PULMONALE, CO.P.D. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ? INTESINAL OBSTRUCTION.										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/21/79, 1979, to 6/14/79, 1979, that (I) (we) last saw the deceased alive on 6/14/79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE W. Dharma Sena					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6/20/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. DHARMA SENA					22e. ADDRESS 2726 N. Charles Ave. - Hoxp - Baltimore 21218					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/25/79		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto. Md			
24 FUNERAL DIRECTOR NAME Burgee Funeral Home						ADDRESS 3631 Falls Road 21211		25a. DATE RECEIVED BY REGISTRAR JUN 25 1979		

13921

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MINNIE MILLER BEDFORD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>06 08 79</b>		2b. HOUR <b>4:39 PM</b>						
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04 18 96</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 74 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STREET ADDRESS) <b>SINAI HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALES LADY</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>HATS</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13e. STREET ADDRESS #21215 <b>6512 EBERLE DR., APT. 102</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>BERNHARDT MILLER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JOHANNA BESSIE BLECHMAN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-22-4523A</b>		17. INFORMANT ADDRESS <b>MRS. LENA LEVENTHAL 6512 EBERLE DR., APT. 102</b>							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arrhythmia CHF</b>			
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Drug Toxicity</b>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) examined and attended from <b>05/25 79</b> to <b>06/08 79</b> , that (I) (we) last saw the deceased alive <b>06/08/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>RAYMOND J. ALTIERI</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>06/08/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAYMOND J. ALTIERI</b>				22e. ADDRESS <b>SINAI</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6-10-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW FRIENDSHIP</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR <b>JUN 13 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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13923

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SAMUEL BELSKY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 14, 1979</b>			2b. HOUR <b>12:45 P.M.</b>				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 14, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY <b>POLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HEBREW SCHOOL</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>APT. 204 6638 EBERLE DR. #21215</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>LAZAR BELSKY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ESTHER UNKNOWN</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-30-7338</b>		17. INFORMANT <b>MRS. RUTH BELSKY</b>			17. ADDRESS <b>6638 EBERLE DR., APT. 204</b>		17. CITY OR TOWN <b>#21215</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute hypotension</b> 4/149 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASVD + coronary artery disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>6/14</b> , 19 <b>79</b> , to <b>6/15</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive <b>6/14</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Stanford Malinow</b>						DEGREE		22c. DATE SIGNED <b>6/15/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STANFORD MALINOW, M.D.</b>						22e. ADDRESS <b>3635 OLD COURT RD. #21208</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>JUNE 17, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HAR SINAI</b>		23d. LOCATION <b>OWINGS MILLS, BALTO. MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS., INC. 6010 Reisterstown rd, Balto., MD 21215</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barry McBrady</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 1 3 9 2 4 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) LORIA B BENNER					2a. DATE OF DEATH MONTH DAY YEAR JUNE 9, 1979			2b. HOUR 539 M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11-22-1925		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE GOOD SAMARITAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND					13b. COUNTY BALTO		13c. CITY OR TOWN WHITEMARSH		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ANGELO PINZUTI					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMELIA DONCOLINE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-22-2813		17. INFORMANT ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY 1991 IMMEDIATE CAUSE (a) METASTATIC ADENO CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from APRIL 27, 1979, to JUNE 9, 1979, that (I) (we) lost saw the deceased alive on JUNE 9, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Halesh M. Patel M.D.					DEGREE M.D.			22c. DATE SIGNED JUNE 9, 79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HALESH M. PATEL, M.D.					22e. ADDRESS THE GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD. BALTO. MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/12/79		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Connelly J.H.					ADDRESS 300 Mace Ave.		25a. DATE REC'D. BY REGISTRAR JUN 14 1979		25b. REGISTRAR'S SIGNATURE Rafael Belmonte	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MORRIS M. BENSON			2a. DATE OF DEATH MONTH DAY YEAR 6 15 79			2b. HOUR 2:40 PM				
3 SEX F		4 RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 3 22 00		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MURRAY HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOSTESS		12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		
13a. STATE MD			13b. COUNTY BALT		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS STELLA MARIS HOSPITAL	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN CRAWFORD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BELLE ELKIN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 169-28-3585		17. INFORMANT ADDRESS FAMILY					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY INSUFFICIENCY, PNEUMOTHORAX</u> (c) <u>MI, BLEEDING EPISODE</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6d, 6d, 6d		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 6 13 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) PT fell. Pk on anti-coagulant					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) MERCY		21f. LOCATION STREET CITY OR TOWN COUNTY STATE BALTIMORE MD					
22a. I certify that (1) this hospital attended the deceased from 6/12/79 to 6/19/79, that (1) (we) lost saw the deceased above, (1) (we) (did not view the body after death) and that in (my) (our) opinion death occurred on the date and hour and from the causes stated										
22b. SIGNATURE [Signature]			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/16/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MOORE			22e. ADDRESS MERCY HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6/18/79		23c. NAME OF CEMETERY OR CREMATORY MORELAND MEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.			
24. FUNERAL DIRECTOR NAME C.F. EVAN 8802 HANFORD RD.					25a. DATE REC'D. BY REGISTRAR JUN 21 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

BP

100-100000



JUNE 1 1972

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 3 9 2 6

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

DORA

BERSHTEIN  
BERSHSTEIN

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

6-1-79

3:05 PM

3 SEX

FEMALE

4 RACE

WHITE

5. DATE OF BIRTH

MONTH

DAY

YEAR

04 05 1896

6 AGE (IN YEARS LAST BIRTHDAY)

83

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MARYLAND

7b. CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE City

MD

10 CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

SINAI HOSPITAL

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

HOUSEWIFE

12b. KIND OF BUSINESS OR INDUSTRY

AT HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

BALTO.

13c. CITY OR TOWN

BALTO.

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

6807 TOWNBROOK DR. #21207

14. FATHER'S NAME

MEYER

MIDDLE

MIRVIS

LAST

15. MOTHER'S MAIDEN NAME

LIBBY

MIDDLE

UNKNOWN

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

216-50-0449

17. INFORMANT

JEROME BERSHTEIN

ADDRESS

3900 BEL PRE RD., WHEATON, MD 20906

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardio pulmonary Arrest

410 -

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Acute Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 5/8 1979 to 6/1 1979, that (I) (we) lost saw the deceased alive on 6/1 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

6/1/79

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Juan Arguazoni

22e. ADDRESS

SINAI Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

JUNE 3, 1979

23c. NAME OF CEMETERY OR CREMATORY

MIKRO KODESH-BETH ISRAEL

CITY OR TOWN

BALTIMORE

COUNTY

STATE

24. FUNERAL DIRECTOR NAME

SOL LEVINSON &amp; BROS., INC.

25a. DATE REC'D. BY REGISTRAR

JUN 6 1979

25b. REGISTRAR'S SIGNATURE

Patricia McCreedy

6010 REISTERSTOWN RD., BALTO., MD 21215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13927

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR											
KARL Joseph BESNOSKA Jr.						6 22 19 79			8:43			P M											
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	7. IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			8:43											
male	white	Jan. 1, 1955	24			6 22 19 79			P M														
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.											
Baltimore, Md.			USA						Baltimore City														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY														
Baltimore			S.T.U. University Hospital			Carpenter			Construction														
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS											
Maryland			Baltimore			Essex 21221			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1914 Poplar Rd.											
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																	
Karl J. Besnoska, Sr.						Anna Little																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OF DATES)			17. INFORMANT			ADDRESS														
Yes			72-74			217 64 3138			Karl J. Besnoska			Same											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> 8132 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
7:10 P.M. 6 22 19 79				driver of motorcycle which struck auto causing subject to fall on street																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
street				Turkey Pt. Rd. & Back River Neck				Essex, Md.															
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> Road my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED															
H. R. Shaid				M.D. Assistant				6/23/79															
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
Hormez R. Guard, M.D.				111 Penn Street																			
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial				6/26/79				Holly Hill Memorial Gardens				Baltimore Co., Md.											
24. FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR								25b. REGISTRAR'S SIGNATURE							
Brzezinski Funeral Home								1407 Old Eastern Ave.								JUN 25 1979							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1 3 9 2 1



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13928

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HENRY C. BETHEA</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 18 79</b>			2b. HOUR M <b>4:35</b> P <b>M</b>		
3. SEX <b>male</b>	4. RACE <b>negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 1 22</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>57</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 18 79</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hosp. (DOA)</b>				12a. USUAL OCCUPATION* (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>		13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>2805 Winwood Court</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Shad Bethea</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>3/28/41-11/8/45</b>		17. INFORMANT ADDRESS <b>Madegline Bethea 2805 Winwood Ct.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic cardiovascular disease</b> <b>4029</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Ann M. Dixon</i>		M.D. <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>6-19-79</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>		ADDRESS <b>111 Penn St.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/22/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>		ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1979</b>		25b. REGISTRAR'S SIGNATURE <i>History Maloney</i>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITALS ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FRANCES A. BEYER</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 3 1979</b>		2b. HOUR <b>M</b>	
3 SEX <b>FEMALE</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 11 1899</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>710 S. LAKEWOOD AVE</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOME MAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>	13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>710 S. LAKEWOOD AVE.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH NOWAK</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216 16 9713</b>		17 INFORMANT ADDRESS <b>NOAH BEYER 710 S. LAKEWOOD AVE</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of the colon, right kidney from carcinoma of uterus</b> 179- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <del>the hospital</del> attended the deceased from <b>May 3</b> , 19 <b>73</b> , to <b>May 15</b> , 19 <b>79</b> , that (I) <del>was</del> last saw the deceased alive on <b>May 15</b> , 19 <b>79</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>viewed</del> (did not) view the body after death.					
22b. SIGNATURE <b>Melito M. Torres</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6-4-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Melito M. Torres, M.D.</b>		22e. ADDRESS <b>441 S. Ellwood Ave. Baltimore, Md. 21224</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>6/7/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS</b>	
23d. LOCATION CITY OR TOWN <b>BALTIMORE</b>		COUNTY <b>BALTIMORE</b>		STATE <b>MD</b>	
24. FUNERAL DIRECTOR NAME <b>RAYMOND L. KACZOROWSKI</b>		ADDRESS <b>3525 FLEET ST</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 5 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>P. J. Healy</b>					

U S C O I R A

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>George Binko</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6/21/79</b>		2b. HOUR <b>10 30<sup>PM</sup></b>							
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 27 18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b>		IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		IF UNDER 24 HRS. HOURS MIN <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.						
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospitals</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>chauffeur</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cab.Co</b>				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6703 O'Donnell Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Binko</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sue Goofus</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213 09 1639</b>		17. INFORMANT <b>Mrs. George Binko</b>			ADDRESS <b>6703 O'Donnell Street</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Necrotic @ Leg; pneumonia</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Status post Myocardial Infarct + CV4</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>David Mishkin</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/21/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David Mishkin MD</b>						22e. ADDRESS <b>Balto City Hosps</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/25/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Of Mary</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md</b>				
24. FUNERAL DIRECTOR NAME <b>Walter Dabrowski</b>						ADDRESS <b>1005 Dundalk Avenue</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. <b>7 9 1 3 9 3 1</b>									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
<b>HOWARD Chester BIRCHAM</b>								<b>JUNE 5, 1979</b>		<b>10:05pm</b>	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS HOURS MIN	
<b>Male</b>		<b>White</b>		<b>Oct. 6, 1906</b>		<b>72</b> YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
<b>Virginia</b>		<b>U.S.A.</b>				<b>BALTIMORE CITY</b> MD.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
<b>BALTIMORE</b>		<b>MARYLAND GENERAL HOSPITAL</b>		<b>Merchant</b>		<b>Food</b>					
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS			
<b>Maryland</b>		<b>Harford</b>		<b>Jarrettsville</b>		<b>ES</b>		<b>3732 Norrisville Road</b>			
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
<b>Fulton</b>		<b>Bircham</b>		<b>Cumbia Quesinberry</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
<b>No</b>		<b>212-03-3494</b>		<b>Bernice A. Bircham</b>		<b>same as above</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC DISEASE</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>OAT CELL CARCINOMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b> <b>1 YEAR</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that <b>x</b> (this hospital) attended the deceased from <b>May 30</b> , 19 <b>79</b> , to <b>June 5</b> , 19 <b>79</b> , that ( <b>x</b> ) (we) lost saw the deceased alive on <b>June 5</b> , 19 <b>79</b> , and that in ( <b>x</b> ) (our) opinion death occurred on the date and hour and from the causes stated above. <b>x</b> (we) (did) <b>not</b> view the body after death.											
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED			
<b>Renee Waschler</b>		<b>M.D.</b>						<b>6/5/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS									
<b>RENEE WASCHLER, M.D.</b>		<b>c/o MARYLAND GENERAL HOSPITAL</b>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
<b>Burial</b>		<b>6/8/1979</b>		<b>Ayres Chapel</b>		<b>White Hall, Harford, Md.</b>					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<b>M. G. Kurtz III</b>		<b>Jarrettsville, Md.</b>		<b>JUN 11 1979</b>		<b>History/Barbuddy</b>					

MEDICAL CERTIFICATION



10-022

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HOWARD STREET BIRMINGHAM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be distributed for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 9 1 3 9 3 2 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALLEENA L. Blackwell					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 6 12 79 1 33 PM					
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 3 2 01		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt. City MD.				
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S. W. K. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md					13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Julius Brown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE Hattie Robinson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 255-36-9320		17. INFORMANT Bennie Hanson		ADDRESS 4905 Lanier Ave.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 410- DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC C-V DWS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1) BRONCHIO PNEUMONIA										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) that hospital attended the deceased from 3/7/79 to 6/13/79, that (2) (we) last saw the deceased alive on 6/13/79, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.										
22b. SIGNATURE Dr. J. S. R. [Signature]				DEGREE MD		22c. DATE SIGNED 6/13/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. J. S. R. [Signature]				22e. ADDRESS 4432 Park Heights Ave 21215						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/15/79		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.				
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE [Signature]		

2 5 6 8 1 4 3 7



1940-1941



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 3 9 3 3

1. DECEASED NAME (TYPE OR PRINT) Ola Mae Blair			2a. DATE OF DEATH MONTH DAY YEAR JUNE 15, 1979			2b. HOUR 1 P.M.				
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 14 14		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Hosie				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Willie Dover						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-22-5106		17. INFORMANT ADDRESS Mr. Leon L. Brown 2326 W. Lexington St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE MYELOMA 2030 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 WEEKS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ARTERIOSCLEROTIC VASCULAR DISEASE										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the <del>physician</del> ) attended the deceased from MAY 29, 19 79, to JUNE 15, 19 79, that (I) <del>was</del> lost saw the deceased alive on JUNE 15, 19 79, and that in (my) <del>an</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did</del> (did) view the body after death.										
22b. SIGNATURE Howard H. Gendason			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED JUNE 15, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD H. GENDASON MD			22e. ADDRESS 2000 W. BALTIMORE ST. BALTO. MD 21223							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-20-79		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md			
24. FUNERAL DIRECTOR NAME Joseph L. Russ			ADDRESS 2322 W. North Ave			25a. DATE REC'D. BY REGISTRAR JUN 25 1979		25b. REGISTRAR'S SIGNATURE H. J. McBrady		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

2 2 1 2 1 2 2



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 1 3 9 3 4	
1- FOR STATE REGISTRAR				REG. NO.							
1 DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
NANNIE E. BLAND								6 14 79		5:05PM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.	
Female		Black		6 15 16		62 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Va.		USA				BALTIMORE CITY MD.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		UNION MEMORIAL HOSPITAL									
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b CITY OR TOWN		13c INSIDE CITY LIMITS?		13d STREET ADDRESS			
13a STATE				13b COUNTY		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d 1733 Homestead Sts			
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Arthur Britton				Molly Ann Green							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT		17 ADDRESS			
No				220-05-9887		Leonard Bland, Jr.		837 E. 30th St.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1619 Disseminated Squamous Cell Ca of LARYNX										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that (I) (this hospital) attended the deceased from 6/13 19 79, to 6/14 19 79, that (I) (we) lost saw the deceased alive on 6/14 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE OF DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>								22c DATE SIGNED			
Anthony J. Valdin M.D.								6/14/79			
23a PHYSICIAN'S NAME (TYPE OR PRINT)						23b ADDRESS					
ANTHONY J. VALDINI M.D.						UNION MEMORIAL HOSPITAL					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		6/19/79		Arbutus Mem. Pk.		Arbutus, Md.					
24 FUNERAL DIRECTOR NAME						24 ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Wm C March F/H						1101 E. North Ave.		JUN 18 1979		Anthony J. Valdin	



13124



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
1/VR A15 ME (5)  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13935  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Francis DeSales Blank</b>			20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 21 1979</b>			21. HOUR M <b>11:05 P M</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 20, 1909 69 YRS.</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>69 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	22. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 21 1979</b>	23. HOUR M <b>11:05 P M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>John L. Deaton Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Md. Casualty</b>
13a. STATE <b>Md.</b>			13b. COUNTY <input checked="" type="checkbox"/> A.A.	13c. CITY OR TOWN <b>Pasadena</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>7604 Paradise Beach</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Leo Blank</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Fowler</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>214-01-9296</b>		17. INFORMANT ADDRESS <b>Mary E. Blank (same as 13e)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>Ankylosing spondylitis and transverse myelitis</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>			M.D. <b>Assistant</b>			DATE SIGNED <b>6/22/79</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>			ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/25/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Geo. J. Gonce, 4001 Ritchie Hg., Baltimore</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony M. Brady</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 4 and 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMM-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
SPENCER				BLANKS				6		11		79		7:30A		M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
MALE		BLACK		3 1 08		71 YRS.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH											
NORTH CAROLINA		U.S.A.				BALTIMORE CITY										MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
BALTIMORE		VA MEDICAL CENTER BALTO.MD.		Bethlehem Steel		Steel											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
MARYLAND				BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		104 LINDEN CT. 21222									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
JAMES		HATTIE															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS											
YES		WW II		243-12-6737		ROSA E. BLANKS		104 Linden Ct.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
1629		Squamous cell carcinoma - lung															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
				(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		Hypercalcaemia															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 19, 19 79, to JUNE 11, 19 79, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 11, 19 79, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (X) (not) view the body after death.																	
22a. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED											
Robert Applebaum MD						6/11/79											
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS															
Robert Applebaum MD		3900 LOCH RAVEN BLVD. BALTO.MD. 21218															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		6/16/79		Holly Hill		Chase Md.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
JAMES A. MORTON & SONS		1701 LAURENS		JUN 13 1979		R. H. Brady											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 1 3 9 3 7	
1- FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>INNES H. Blankenship</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 8 79</b>		2b. HOUR <b>03:00 AM</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb 18 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN <b>77</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIV OF Md Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD</b>			13b COUNTY <b>Baltimore</b>	13c CITY OR TOWN <b>Baltimore</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Howard Blankenship</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LAVIA H. Lucas</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>UNK</b>		17 INFORMANT ADDRESS <b>Family Records</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b> <b>4415</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypovolemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Rupture of Aortic aneurysm</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min / sec</b> <b>1 min sec</b> <b>sec</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6/8 1979</b> to <b>6/8 1979</b> , that (I) (we) last saw the deceased alive on <b>6/8 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE DEGREE <b>Ray Brodie Jr MD</b>				22c. DATE SIGNED <b>6/8/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAY Brodie Jr MD</b>				22e. ADDRESS <b>UNIV OF Md Hosp. Balt. Md</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>6/11/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>					
24. FUNERAL DIRECTOR NAME <b>EVANS Funeral Chapel 8800 HANFORD Rd</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>History McCreedy</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession of this certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										9 1 3 9 3 8 REG. NO.	
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) Cecelia T. Boebel						2a. DATE OF DEATH MONTH DAY YEAR June 27, 1979		2b. HOUR 07:39pm			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 11, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY		13c. CITY OR TOWN Baltimore			
14 FATHER'S NAME FIRST MIDDLE LAST Conrad C. Maygers						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Mathias					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-01-5816		17 INFORMANT ADDRESS John E. Boebel 4207 Hamilton Ave.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> 4249 DUE TO, OR AS A CONSEQUENCE OF (b) <u>VALVULAR HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>POSSIBLE PULMONARY EMBOLI.</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>June 27</u> , 19 <u>79</u> , to <u>June 27</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>June 27</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Nisha Chandra</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>June 27/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>NISHA CHANDRA</u>				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 30, 1979		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Jesus Baltimore		23d. LOCATION CITY OR TOWN COUNTY STATE Maryland					
24 FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Md.				25a. DATE REC'D. BY REGISTRAR JUN 28 1979		25b. REGISTRAR'S SIGNATURE <u>Nisha Chandra</u>					

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Cecilia



The Johns Hopkins Hospital

Baltimore



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>RAYMOND Romuald T. Bonczek</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6 14 79</b>				2b. HOUR <b>5:20 P.M.</b>	
3. SEX <b>M</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 1 02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto City</b> MD			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tailor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>				13b. COUNTY <b>D</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Anthonay Bonczek</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Antonia Bonczek</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>None</b>				16b. SOCIAL SECURITY NO. <b>216-075529</b>		17. INFORMANT ADDRESS <b>Anna Bonczek Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction,</b> <b>440-</b> DUE TO, OR AS A CONSEQUENCE OF Cardiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____									
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>None 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6-11</b> 19 <b>79</b> , to <b>6-14</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6-14</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>David Chen</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID CHEN</b>				22e. ADDRESS <b>Good Samaritan Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>6-18-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>RAYMOND L. KACZOROWSKI 3525 FLEET ST.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 20 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Prof. J. K. Brady</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
1. FOR STATE REGISTRAR		REG. NO.		7 1 3 9 4 0											
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
RONALD M BONHS				6		23		79				M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		White		7 MONTH 17 DAY 39 YEAR		39		MONTHS		DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Baltimore		USA				BALTIMORE CITY MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		UNION MEMORIAL HOSPITAL													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
				Maryland		Harford		Belair, Md		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		516 Woodbury Way 21014			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
John				Helen				Dembeck							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS							
no				214 28 4978				Mrs. Mary Ann Bonhs 516 Woodbury Way							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) CARDIAC ARREST												40 mi			
410- DUE TO, OR AS A CONSEQUENCE OF															
(b) PROBABLE MYOCARDIAL INFARCTION												40 mi			
DUE TO, OR AS A CONSEQUENCE OF															
(c) ASCVD												40 mi			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
History of myocardial infarction & Cardiac arrest															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
				HOUR A.M. MONTH DAY YEAR											
				P.M. 19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6/20, 1979, to 6/23, 1979, that (we) last saw the deceased alive on 6/23, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE				DEGREE				22c. DATE SIGNED							
Donald T. Weglein MD				Resident				6/23/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
DONALD T. WEGLEIN				Union Memorial Hosp											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				6/26/79		Oak Lawn				Baltimore COUNTY Maryland					
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Walter Dabrowski						1005 Dundalk Avenue				JUN 27 1979					

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CHARTERED BY THE BOARD OF DIRECTORS

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

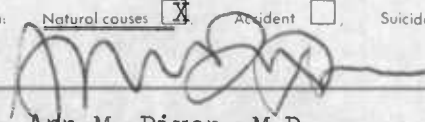

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

13941

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BLANCH</b>			2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 6 5 19 79			2b. HOUR M		
3. SEX <b>female</b>	4. RACE <b>negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 2 1916</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>63</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD <b>6 5 19 79</b>	7d. HOUR a M <b>10:38</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>908 Bevan St.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md</b>		13b. COUNTY <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>908 Bevan Street</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Boone</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maggie ?</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219 22 3574</b>		17. INFORMANT ADDRESS <b>Joseph Boone 908 Bevan Street</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic alcoholism</b> 303- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. <b>Assistant</b>		MEDICAL EXAMINER		DATE SIGNED <b>6-5-79</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>		ADDRESS <b>111 Penn St.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-9-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Isaiah L. Brown &amp; Son PA 1913 W. Balto. St.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 6 1979</b>		25b. REGISTRAR'S SIGNATURE 		

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 3 9 4 2									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Henry G. Boss								6 7 79		12 15 M	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.	
Male		White		Nov. 5, 1888		90 years YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore City, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
Baltimore		201 S. Beechfield Avenue 21229									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Machinist		Dell Brush									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.				Baltimore				201 S. Beechfield Avenue 21229			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
August Boss				Anna E. Dill							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
YES WW I				213-10-7961		Mrs. Catherine Boss, 210 S. Beechfield Ave. 21229					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial C.V.A.</u> <u>436-</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alcohol poisoning, Chronic Von Reck-Solow</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>age</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>3/21</u> , 19 <u>68</u> , to <u>6/7</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>4/12</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Cliff Ratliff</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/7/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Cliff Ratliff, M.D.						22e. ADDRESS 5772 Westview Mall					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		6/11/79		Western Cemetery		Baltimore City, Maryland					
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hubbard Funeral Home, Inc.				4107 Wilkens Ave, Balto., Md. 21229		JUN 11 1979		<u>Anthony McBrady</u>			

MEDICAL CERTIFICATION

BP

2. 4. 5.





13

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 3 9 4 3

1. DECEASED NAME (TYPE OR PRINT) NORMAN C. BOSWORTH			2a. DATE OF DEATH MONTH DAY YEAR 06 11 79		2b. HOUR 9 P M							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1935		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN		8. UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South America		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.						
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dependent		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2303 Pentland Dr. 21234			
14. FATHER'S NAME FIRST MIDDLE LAST Kenneth M. Bosworth			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth E. Holway									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-56-6267			17. INFORMANT Mrs. Margaret B. Ford			ADDRESS Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN DEATH</u> 514- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u><del>PULMONARY</del> Cerebral Anoxia</u> (c) <u>PULMONARY EDEMA</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 29 hrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Hx of mental retardation, hypothyroidism, depression, cigarette smoking</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22. I certify that (1) (this hospital) attended the deceased from <u>on 6/11/79</u> to <u>on 6/11/79</u> , that (2) (we) last saw the deceased alive on <u>6/11/79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (3) (we) (did) (did not) view the body after death.												
22a. SIGNATURE <u>Michael A. Stang</u>			DEGREE MD.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6/11/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael A. Stang</u>			22e. ADDRESS <u>c/o Union Memorial Hospital</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE June 13, 1979		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN Baltimore		COUNTY Maryland		STATE	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.						ADDRESS Balto, Md.		25a. DATE REC'D. BY REGISTRAR JUN 13 1979		25b. REGISTRAR'S SIGNATURE <u>Pitney Melby</u>		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13944	
1- FOR STATE REGISTRAR						2a. DATE OF DEATH		MONTH DAY YEAR		7b. HOUR	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>OLIVER BOUCHER</b>						6 13 79		19		A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
male		white		Nov. 2, 1893		85 YRS.		MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD	
1a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U S A				Baltimore City					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore				611 Park Avenue				sales		tobacco	
13a. STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland						Balto. Cty.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
Wm.						Louisa A. Baker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
yes				217 01 5732		Mrs. Charles J. Peace 5001 Bonadmore Rd. 21212					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
								CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Margarita A. Korell, M.D.				Assistant				6/13/79			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Margarita A. Korell, M.D.				111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial				6/16/79		Lorraine Park Cem.		Balto. Co. Md.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
J. J. Stansbury Jr. 6411 Windsor Mill Rd.				JUN 21 1979				Lorraine Park Cem.			







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 3 9 4 5

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MICHAEL STEVEN BOWERS		2a. DATE OF DEATH MONTH DAY YEAR 6 8 79 2b. HOUR 1 A M	
3. SEX MALE	4. RACE WHITE	5. AGE (IN YEARS LAST BIRTHDAY) 26 YRS	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL	9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST RODNEY BOWERS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KAY LEVIN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS MRS. KAY REED 4319 DEERPARK RD. #21133			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) SEVERE MENTAL RETARDATION			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 5-0 1979 to 6-8 1979, that (I) (we) last saw the deceased alive on 6-8 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22a. SIGNATURE P. H. SEIGEL		22b. DEGREE U. of Md. Hosp	
22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-8-79	
23c. NAME OF CEMETERY OR CREMATORY BNAI ISRAEL CONG.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR JUN 13 1979	
25b. REGISTRAR'S SIGNATURE R. H. Seigel			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

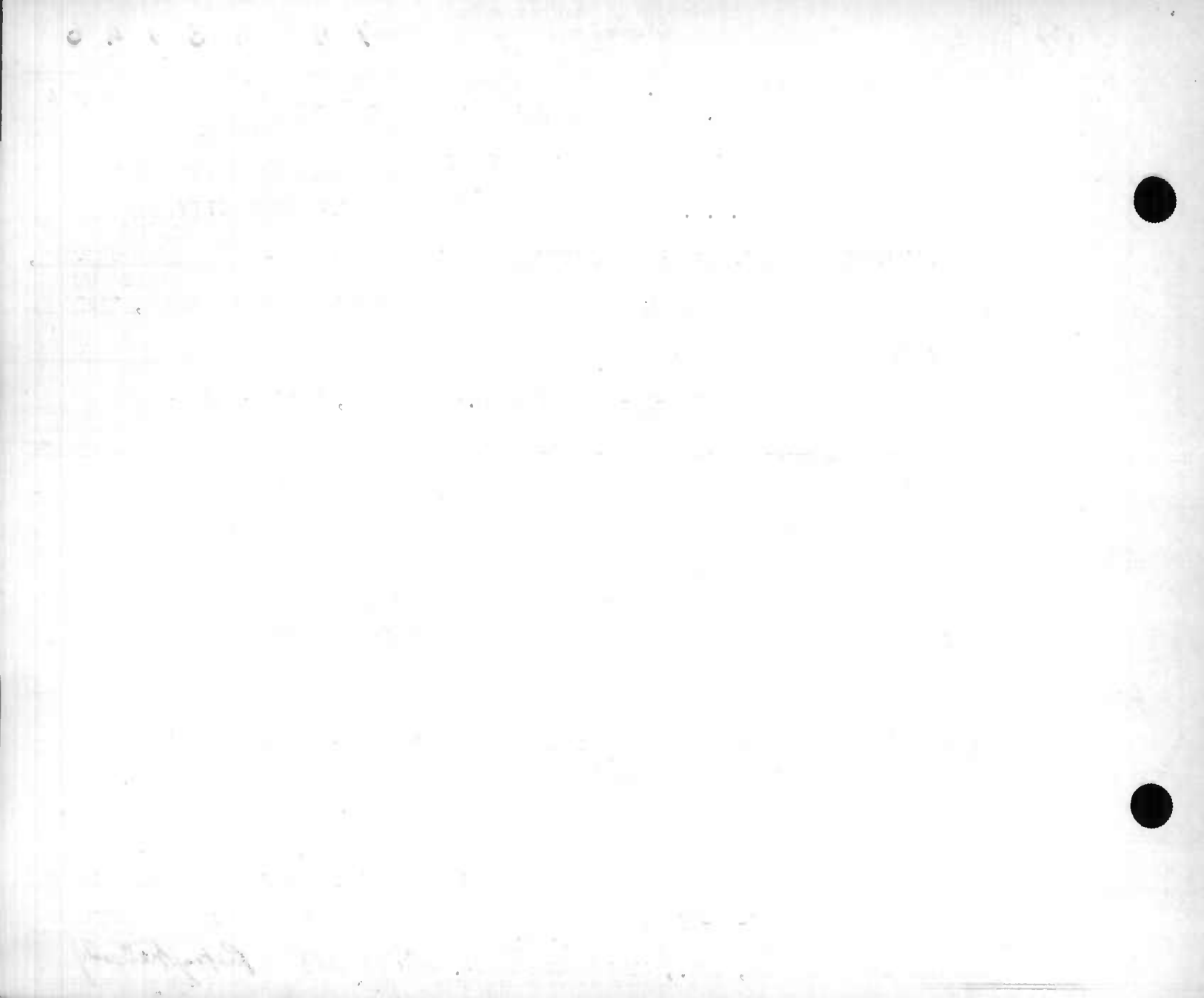
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) AKA FIRST BESSIE MIDDLE L. LAST BEALEFELD BESSIE L. BOWSER				2a. DATE OF DEATH MONTH DAY YEAR 6-4-79				2b. HOUR 6:10 A.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 02 05 35		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAITRESS - COOK		12b. KIND OF BUSINESS OR INDUSTRY FOOD SERVICE	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS CARRY OUT 2026 WHISTLER AVENUE, 21230	
14. FATHER'S NAME FIRST MIDDLE LAST TROY CRUISE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 220-30-1276		17. INFORMANT ADDRESS JOHN B. BEALEFELD, 2026 WHISTLER AVENUE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 4301 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL EDEMA</u> (c) <u>SUBARACHNOID HEMORRHAGE</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION 5-11-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ANEURYSM L. CAROTID ARTERY				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-26</u> , 19 <u>79</u> , to <u>6-4</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6-4</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M.H. Budeir M.D.						22c. DATE SIGNED 6-4-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.H. BUDEIR				22e. ADDRESS 900 CATON AVE. BALTIMORE, MD. 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 06-05-79		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.				25a. DATE REC'D. BY REGISTRAR JUN 6 1979		25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 1 3 9 4 7 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Charles Robert Boyer</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>June 8, 1979</b>		2b. HOUR <b>6:58 P M</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 12, 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>50</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Chauffeur</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryldn</b>		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>603 Alvin Ave</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>late Dudley Boyer</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eva Belle Hansen</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>220 24 5185</b>		17. INFORMANT ADDRESS <b>Mrs Arlene Boyer 603 Alvin Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>4254</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Chronic Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Distal myocardial infarction</b> <b>444r.</b> <b>419rs</b> <b>444rs</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <b>Base with mitral regurgitation</b>					
19a. DATE OF OPERATION <b>Jan 1978</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>three vessel disease cath.</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6/2/79</b> <b>1966</b> , to <b>6/8/79</b> , that (I) <del>have</del> last saw the deceased alive on <b>6/2/79</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <b>did not</b> view the body after death.					
22b. SIGNATURE <b>W E McGraham MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/11/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W E McGraham MD</b>		22e. ADDRESS <b>1303 Frederick Rd Catonsville 21048</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 12, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Harry H. Witzke 4112 Columbia Rd Ellicott City</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 13 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>Harry H. Witzke</b>					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13948

1- STATE REGISTRAR		20. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		21. DATE OF DEATH		22. HOUR	
ISIAH		BRADLEY JR.		6 17 19 79		5:45 a	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. BALTIMORE CITY OR COUNTY OF DEATH	
male	negro	NOV 28 1952	26 YRS.			Baltimore City	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	11. CITIZEN OF WHAT COUNTRY?		12. MARRIED		13. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	USA		NEVER MARRIED		Baltimore City		
14. CITY OR TOWN OF DEATH	15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		16. USUAL OCCUPATION		17. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Loch Raven V.A. Hospital		UNEMPLOYED				
18a. STATE	18b. COUNTY	19. CITY OR TOWN	20. INSIDE CITY LIMITS?	21. STREET ADDRESS			
MARYLAND		BALTIMORE	YES	3907 W. MULBERRY STREET			
22. FATHER'S NAME		23. MOTHER'S MAIDEN NAME		24. ADDRESS			
ISIAH		GENEVA		MOORE			
25. WAS DECEASED EVER IN U.S. ARMED FORCES?		26. SOCIAL SECURITY NO.		27. INFORMANT			
YES VIETNAM		212 56 9787		MR. ISIAH BRADLEY 3907 W. MULBERRY STREET			
28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Pulmonary embolism							
DUE TO, OR AS A CONSEQUENCE OF							
(b) DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1							
29a. DATE OF OPERATION		29b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			30. AUTOPSY?		
					YES NO		
31a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		31b. TIME OF INJURY		31c. HOW INJURY OCCURRED			
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
32a. INJURY OCCURRED WHILE NOT WHILE AT WORK		32b. PLACE OF INJURY		32c. LOCATION			
		(AT HOME, STREET, FACTORY, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
33. I certify that I took charge of the remains described above, held on Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner							
34. ACTUAL SIGNATURE		35. TITLE (SPECIFY)		36. DATE		37. SIGNED	
Ahn M. Dixon, M.D.		Assistant		6-19-79			
38. EXAMINER'S NAME		39. ADDRESS		40. LOCATION			
(TYPE OR PRINT)				CITY OR TOWN COUNTY STATE			
Baltimore		111 Penn St.		BALTIMORE (AA) MARYLAND			
41. BURIAL, CREMATION, REMOVAL		42. DATE		43. NAME OF CEMETERY OR CREMATORY		44. LOCATION	
BURIAL		6/22/79		CEDAR HILL CEMETERY		BALTIMORE (AA) MARYLAND	
45. FUNERAL DIRECTOR		46. DATE REC'D. BY REGISTRAR		47. REGISTRAR'S SIGNATURE			
LEWIS T. GWYNN		JUN 19 1979		Rafael McCreedy			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 9 13949	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Bernard</b>		MIDDLE <b>M.</b>		LAST <b>Branch</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>June 7 1979</b>		2b. HOUR <b>6 17 A M</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 3 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Warehouseman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Western Auto</b>			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>None</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Unobtainable</b>	
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>L.</b> LAST <b>Branch</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Nannie</b> MIDDLE <b>Maude</b> LAST <b>Unobtainable</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>Unobtainable</b>		17. INFORMANT ADDRESS <b>Thacker Bros., Funeral Home, Scottsville, Va.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive hemoptysis</b> <b>303-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Right lower lobe pneumonia, with extension to both lungs</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>possible aspiration</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Thrombocytopenia: Nutritional deficiency 2° to alcohol use</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <b>May 31</b> , 19 <b>79</b> , to <b>June 7</b> , 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>June 7</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Gregory D McCormack</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>6/7/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gregory D McCormack</b>				22e. ADDRESS <b>Mercy Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/11/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Scottsville</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Scottsville, Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>E.G. Semely</b> ADDRESS <b>CORNINGHAM Hwy. Va.</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>John H. McCreedy</b> <b>JUN 18 1979</b>							

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
MUMFORD BRANDON			6/22/79			6 22 79 145 P M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	Black	11 11 25	53 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia	USA		BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	THE JOHNS HOPKINS HOSPITAL							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland						Baltimore		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. STREET ADDRESS		
JONES			ELLIE			1712 Holbrook St.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
No			225-26-9689			HALLIE CARLER Same As Above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Aspiration of gastric contents								1 hour
496- DUE TO, OR AS A CONSEQUENCE OF								
(b) Severe chronic obstructive pulmonary disease 10 years								
DUE TO, OR AS A CONSEQUENCE OF								
(c) Smoking over unknown weeks								20 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)								
Severe pneumonia ? common bile duct stone								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		HOUR A.M. MONTH DAY YEAR						
		P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from June 16, 1979, to June 22, 1979, that (1) (we) lost saw the deceased alive on June 22, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE				22c. DATE SIGNED
James L. Abbuzzese M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				6/22/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				
James L. Abbuzzese				Johns Hopkins Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		STATE
Burial		6/28/79		WESTVIEW MEM. PK.		BALTIMORE		MD.
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
NAME Wm. C. March F/H 1101 E. North Ave.				JUN 25 1979		Richard McBrady		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon pages, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 1 3 9 5 1 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Charles William Braun					2a. DATE OF DEATH MONTH DAY YEAR 6 30 79					2b. HOUR 1:45 AM
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 18, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 65 years YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2226 Eagle Street 21223				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Buyer		12b. KIND OF BUSINESS OR INDUSTRY J. Norman		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 2226 Eagle Street 21223	
14. FATHER'S NAME FIRST MIDDLE LAST Charles William Braun					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Kline					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					16b. SOCIAL SECURITY NO. 217-03-2657		17. INFORMANT ADDRESS 21229 Mr. Ottavis Coruzzi, 3915 Wilkens Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma of Liver</u> (c) <u>Bronchiogenic Carcinoma of Lung</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Months Year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>ASCVD with congestive heart failure</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (his hospital) attended the deceased from <u>FEB 19 79</u> , to <u>6-27 19 79</u> , that (1) (my) lost saw the deceased alive on <u>6-27 19 79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (s) (e) (d) did not view the body after death)										
22b. SIGNATURE <u>William R. Law</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-30-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Law, M.D. WILLIAM R. LAW, M.D.						22e. ADDRESS 2000 W. BALTO. ST. BALTO. MD 21223				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/3/79		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland				
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.						ADDRESS 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR JUL 2 1979		
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>										

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Fred J. Braun</b>			2a. DATE OF DEATH MONTH <b>6</b> DAY <b>11</b> YEAR <b>79</b>			2b. HOUR <b>7:30</b> M			
3. SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH <b>May</b> DAY <b>11</b> YEAR <b>1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Newark N. J.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>536 W. University Pky</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. VanSant &amp; Dugdale</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Paul</b> MIDDLE <b>Valentine</b> LAST <b>Braun</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Gertrude</b> MIDDLE <b>M.</b> LAST <b>Zillioux</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>137-01-5697A</b>		17. INFORMANT ADDRESS <b>Mrs. Fred J. Braun 536 W. Univ. Pky</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Monocyte Leukemia</b> 2069 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>1956</b> CITY OR TOWN <b>6-11-79</b> COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>6-11-79</b> to <b>6-11-79</b> , that (I) (we) lost <b>6-11-79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE <b>William G. Helfrich</b>					DEGREE <b>MD</b>		22c. DATE SIGNED <b>6-13-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William G. Helfrich</b>					22e. ADDRESS <b>5006 Roland Ave</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/14/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memo Gds. Timonium, Md</b>		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home 6500 York Rd.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McCreedy</b>		

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 1 3 9 5 3	
1 - FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>MAX BRENTER (BRENDER)</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 27 1979</b>				2b. HOUR <b>8:50 A.M.</b>		
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 10 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) <b>Austria</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY - BALTIMORE</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LEVINVALE HEBREW GERIATRIC CENTER + HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>LADIES DRESSES</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MARYLAND</b> 13c. CITY OR TOWN <b>BALTIMORE</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3917 PINKNEY ROAD 21215</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>DAVID MEYER BRENDER</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SHAINDEL UNKNOWN</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>082-09-0713</b>		17. INFORMANT <b>KIRSCHENBAUM BROS., INC.</b> <b>1153 CONEY IS. AVE., BROOKLYN, NY 11230</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>&lt; 1 day</b>	
410 - DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>LLL PNEUMONIA</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <b>MAY 21 19 79</b> to <b>JUNE 27 19 79</b> , that (we) last saw the deceased alive on <b>JUNE 27 19 79</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.											
22b. SIGNATURE <b>Estrelita O. Kull</b> DEGREE <b>MD.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>6/27/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ESTRELITA O. KULL</b>				22e. ADDRESS <b>LEVINVALE HEBREW GERIATRIC CENTER - Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL</b>				23b. DATE <b>JUNE 27, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>UNITED HEBREW</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>STATEN ISLAND NEW YORK</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>			
6010 REISTERSTOWN RD. BALTO., MD 21215											

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

7 9 1 3 9 5 4

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ANTHONY F. Brigandi</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>6 18 79</b>		2b. HOUR <b>10:20 AM</b>	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>09-30-94</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ITALY</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET AND ADDRESS) <b>5315 W. CONANT ST. Home 4601 Ball Mall Rd.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SHIP WORKER</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>116 S. Haven St.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carmen - Brigandi</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carmella - Vita</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>215-I2-3145</b>		17. INFORMANT ADDRESS <b>Carrie Brigandi 116 S. Hanover St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF <b>ASCU</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>Coronary artery disease</b> (b) (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b): <b>7x Right Hip</b>					
19a. DATE OF OPERATION <b>6/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>7x Hip</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6/8 19 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>6/8</b>		21f. LOCATION CITY OR TOWN COUNTY STATE <b>White Marsh, Maryland</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>6/8 19 79</b> , to <b>6/18 19 79</b> , that (I) (we) last saw the deceased alive on <b>6/18 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Wickson</b>		DEGREE		22c. DATE SIGNED <b>6/18/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WICKSON</b>		22e. ADDRESS <b>3502 W. Regumone</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 21, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Cemetery</b>	
24. FUNERAL DIRECTOR NAME <b>Lilly &amp; Zeiler Inc.</b>		ADDRESS <b>1901 Eastern ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 20 1979</b>	
25b. REC'D. BY REGISTRAR <b>2607 BP</b>		25c. REC'D. BY REGISTRAR <b>2607 BP</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post a copy of this certificate in the hospital or attending physician's office.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 1 3 9 5 5 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>LILLIE B. BRIGGS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6/27/79</b>			2b. HOUR <b>9:20 P.M.</b>	
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 22 10</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Great Falls S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b>			13c. COUNTY <b>Balto</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>706 Radnor Avenue</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>William G. Gaither</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie Barber</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. <b>244-30-6812</b>		17 INFORMANT ADDRESS <b>Geraldine G. Cox 1423 N. Decker Ave.</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA of Colon with 2° Pulmonary 10 YRS. Infiltrate</b> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>6-6</b> 19 <b>79</b> to <b>6-27</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/27</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Lisa M. Bookert M.D.</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6/27/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LISA M. BOOKERT M.D.</b>						22e. ADDRESS <b>6827 Bonnie Ridge Drive, Apt. 101, BALTIMORE</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7-3-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Randstown Maryland</b>		
24 FUNERAL DIRECTOR NAME <b>James A. Morton and Sons</b>						ADDRESS <b>1701 Laurens</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1979</b>	
						25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 9 9 1 3 9 5 6			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET M. BRIGHT				2b. HOUR M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 24 19		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13e. STREET ADDRESS 2606 Aswego Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Steven Sheard				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Staton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-12-0693		17. INFORMANT Rose Cox		ADDRESS 2606 Aswego Avenue	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> 1509 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ESOPHAGEAL CARCINOMA &amp; METASTASES</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>AND MALIGNANT TRACHEO-ESOPHAGEAL PISTULA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION 6/5/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED MALIGNANT TRACHEO-ESOPHAGEAL PISTULA		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 4</u> , 19 <u>79</u> to <u>JUNE 28</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>JUNE 28</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jerome S. Marave				DEGREE		22c. DATE SIGNED 6/28/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEROME S. MARAVE				22e. ADDRESS PROVIDENT HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/3/79		23c. NAME OF CEMETERY OR CREMATORY Elmwood Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Goldsboro, N.C.	
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUL 2 1979	
						25b. REGISTRAR'S SIGNATURE Anthony McBrady	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 9 13957									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
NATHALIA		BRIGHTFUL						JUNE 21, 1979		5:15PM	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
FEMALE		NEGROID		9-9-26		52 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.					
Md.		U.S.A.									
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTO.		HOPKINS HOSPITAL									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.				BALTO.				3501 GWYNNE FALLS PARK			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Wm. JESSUP				GLADYS JONES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
				217-23-9825		ANN THOMAS LINDSAY 2230 GARRISON					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Hypertension / shock											
DUE TO, OR AS A CONSEQUENCE OF, (b) G. Coli sepsis / obstructive cholangitis											
DUE TO, OR AS A CONSEQUENCE OF, (c) Pancreatic carcinoma											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
6/20/79		obstructive jaundice									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from June 17, 1979, to June 21, 1979, that (I) (we) lost the deceased alive on June 21, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Cam E. Smith				M.D.				6/21/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
DAVID BUSH				Johns Hopkins Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		6-27-79		CRESTMOWN Cem		Howard Co., Md.					
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Vernon R. Bailey				1348 Calhoun St.		JUN 27 1979		[Signature]			

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TO HOSPITALS: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR				REG. NO. 9 1 3 9 5 8					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
FIRST MARY MIDDLE R. LAST BRITT				MONTH 06 DAY 28 YEAR 79				10 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		7. IF UNDER 1 YEAR	
Female		white		MONTH Sept. 17, YEAR 1974		64 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Penna.		USA				BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		UNION MEMORIAL HOSPITAL				Fitter		Clothing	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. CITY OR TOWN		13c. STREET ADDRESS			
13a. STATE Maryland				13b. Baltimore		13c. Baltimore			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Nicholas Bollettino				FIRST MIDDLE LAST Millie Sitaro					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no				171-01-4769		Wayne A. Britt 803 Reverdy Road			
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> <u>4349</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Infarction of R middle cerebral artery</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 minute</u> <u>6 days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pneumonia, anemia, hypothyroidism</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/28/79</u> , 19 <u>79</u> , to <u>6/28</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/28</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Gregory B. Faith, M.D.</u>				DEGREE				22c. DATE SIGNED <u>6/28/79</u>	
				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GREGORY FAITH</u>				22e. ADDRESS <u>Union Memorial Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		6/30/79		Meadowridge Cemetery		Dorsey Howard			
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Amrose Funeral Home 1328 Sulphur Sprigg Rd.				JUN 29 1979		[Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
1. FOR STATE REGISTRAR		7 9 1 3 9 5 9 REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		7b. HOUR	
Lazo						Brkljac		6		21		79				M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
Male		W		MONTH 3 DAY 6 YEAR 1895		84		YRS		MONTHS		DAYS		HOURS		MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Yugoslavia		USA				Baltimore		City								MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		Jewish Nursing Home		laborer		C.C.C.Co											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		601 Wyanoke Avenue									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST							
Rade				Brkljac		Stoya						Dragsc					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS											
no		577 20 1566		Mrs. Mary Sobus		403 S. Eden Street											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> <u>2030</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from <u>5/79</u> , 19 <u>79</u> , to <u>6/22</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/10</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>WILFSON</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/22/79</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
Walter Dabrowski		350 W. Rogers															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		6/23/79		Loudon Park		Baltimore, Maryland											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Walter Dabrowski		1005 Dundalk Avenue		JUN 27 1979		<u>Robert H. Brady</u>											



100-118140-1



no  
name

277 20 1500 Mrs. Mary Jones 403 S. Eden Street  
Baltimore  
Baltimore

Baltimore

Jewish Nursing Home

laborer

501 Yarnoke Avenue

Irish

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1893

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Baltimore

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Baltimore

London Park

0/23/79

1893

1005 Dandale Avenue

1005 Dandale Avenue

Baltimore, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed in the funeral director's office. The funeral director should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and file them with the State Dept. of Health and Mental Hygiene. Burial, cremation, or removal of the body must be notified of once.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

DHMH - 16 50M/77  
(VRA 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>STEPHEN E. BRODE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 02 1979</b>			2b. HOUR <b>04:55AM</b>				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCTOBER 8, 1951</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>27</b> YRS.		7. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTO., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>MD.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PATTERSON PARK ACTIVITIES CTR.</b>		
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLIENT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PATTERSON PARK ACTIVITIES CTR.</b>		
13a. STATE <b>Md.</b>					13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>RAYMOND A. BRODE</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LOUISE M. BRAUN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>219-74-3582</b>		17. INFORMANT ADDRESS <b>MRS. LOUISE M. FRENCH 233S. DURHAM ST.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Jepais</b> <b>5733</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hepatic</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6-24 hr</b> <b>2 days</b> <b>2 weeks</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Dominant syndrome with respiratory</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>5/24</b> , 19 <b>79</b> , to <b>6/2</b> , 19 <b>79</b> , that (I) (we) saw the deceased alive on <b>6/2</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Wm Rector</b>					DEGREE <b>Imp</b>			22c. DATE SIGNED <b>6/3/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wm Rector</b>					22e. ADDRESS <b>601 N Broadway Balt</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>JUNE 5, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEMORIAL PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO., Md.</b>			
24. FUNERAL DIRECTOR <b>J. Walter Conklin</b>					ADDRESS <b>5444 BELAIR Rd. 21206</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>John A. [Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 1 3 9 6 1 REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MILDRED E BrodKin</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>June 3, 1979</b>			2b. HOUR <b>8:15 P M</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 18 1902</b>		6. AGE (IN YEARS- LAST BIRTHDAY) MONTHS DAYS <b>76 YRS</b>		IF UNDER 1 YEAR IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Charles General</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Shipiro Cloth Co.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN <b>Maryland Baltimore Dundalk</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>929 Short Road</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Herman E. Redemann</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret C. Lawson</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-14-3077</b>		17. INFORMANT ADDRESS <b>Helen B. Ardis 929 Short Road Balto. MD 21222</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Gall Bladder - metastasis</b> <b>1560</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Severe Anemia due to G. I. Bleeding due to above.</b> (c) <b>to above.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>One year</b> <b>2 months.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1971</b> to <b>June 3, 1979</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>June 3, 1979</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death.									
22b. SIGNATURE <b>Atollah Golpira</b>				DEGREE <b>MD.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6-3-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ATAOLLAH GOLPIRA, M.D.</b>				22e. ADDRESS <b>3029 Dundalk Ave. Baltimore, Md. 21222</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/6/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Baltimore Maryland</b>			
24. FUNERAL DIRECTOR <b>Duda-Ruck, Inc.</b> NAME ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 3 9 6 2

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
(BABY GIRL) BROOKS		6 25 1979		5:10 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR
FEMALE	BLACK	MONTH DAY YEAR	MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.
		6 24 1979	YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	U.S.A.		BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE	UNIVERSITY OF MARYLAND HOSP.		- INFANT		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
13a. STATE 13b. COUNTY		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	914 ARLINGTON AVE. 21217		
MARYLAND					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
NOT KNOWN		NORMA		BROOKS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
NO		NONE	PATIENT'S HOSPITAL CHART		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) CARDIAC ARREST					0 HOURS
7689 DUE TO, OR AS A CONSEQUENCE OF					
(b) ANOXIA AT BIRTH					1 DAY
DUE TO, OR AS A CONSEQUENCE OF					
(c) PREMATURITY					1 DAY
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
NONE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
NONE		NOT APPLICABLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		N/A 19		N/A	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 25, 1979, to June 25, 1979, that (I) (we) last saw the deceased alive on June 25, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Marianne Friberg MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		6/25/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
MARIANNE FRIEBERG MD		22 S. GREEN ST. BALTIMORE, MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
REMOVAL		7/5/79			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Anatomy Board		Balto., Md.		JUL 11 1979	



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WAVE FIVE

2024 COLTON 3100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The **DM** requires that the death certificate be presented within 48 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 7/77  
(VRA 15(4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JULIA Ann BROOKS		JUNE 22, 1979		4:42A <sub>M</sub>	
3 SEX Female	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 10 23 1902		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Roxboro, N.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Grant Smith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Jeffers		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 216-05-2982		17. INFORMANT ADDRESS Morean Scott 1737 E. Oliver Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 21st</u> , 19 <u>79</u> , to <u>June 22nd</u> , 19 <u>79</u> , that (I) <u>was</u> lost saw the deceased alive on <u>June 22nd</u> , 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did not</u> (did) view the body after death.					
22b. SIGNATURE <u>Dr. L. E. Shary</u>		DEGREE		22c. DATE SIGNED 6.22.79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHANDRA NISHA		22e. ADDRESS JOHNS HOPKINS HOSP. BALT. MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/26/79		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.	
23d. LOCATION CITY OR TOWN Arbutus		COUNTY Maryland		STATE	
24. FUNERAL DIRECTOR NAME WM. C. MARCH/1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 26 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony A. Crosby</u>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR Items 18b.

1. STATE FILM#G533 7-16-79 as REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Vivienne			FIRST MIDDLE LAST Brooks			2a. DATE OF DEATH MONTH DAY YEAR 6/14/79			2b. HOUR 5:06 PM		
3. SEX Female			4. RACE Black			5. DATE OF BIRTH MONTH DAY YEAR 12 13 21			6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Balt. City MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secour Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY			13c. CITY OR TOWN Balt.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 141 16 7214		
17. INFORMANT ADDRESS MRS. ELIZABETH STALEY 3425 PATON AVENUE			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Subarachnoid Hemorrhage - 430 - DUE TO, OR AS A CONSEQUENCE OF Cerebral congenital aneurysm (Berry) (b) Possible Rupture of Cerebral aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) Aortic Hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6/2 1979, to 6/14 1979, that (I) (we) last saw the deceased alive on 6/14 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Dr. [Signature]			22c. DATE SIGNED 6/14/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VANDERLIND F. ALBUQUERQUE			22e. ADDRESS 8548 Folsomwood Rd Baltimore Md 21222								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6/21/79			23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME LEWIS T. GWYNN			ADDRESS 4517 PARK HEIGHTS AVENUE			25a. DATE REC'D. BY REGISTRAR JUN 19 1979			25b. REGISTRAR'S SIGNATURE [Signature]		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1 - STATE REGISTRAR					REG. NO. 13965				
1. DECEASED NAME (TYPE OR PRINT) <i>William R Brooks</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>6-5-79</i>			2b. HOUR <i>6:25</i> M	
3. SEX <i>Male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8 8 09</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Balto.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Provident Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md.</i>		13b. COUNTY		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Clarence Brooks</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bernice Scott</i>		13e. STREET ADDRESS <i>4230 Evans Chapel Rd.</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WWII 216-01-0521</i>		17. INFORMANT ADDRESS <i>Caroline E. Brooks 4230 Evans Chapel Rd.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Car dis pulmonary arrest</i> 496- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Obstructive Pulm. disease</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>5-29-1979</i> , to <i>6-5-1979</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>6-5-1979</i> , and that in <i>our</i> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (I) (we) (did) <input type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE <i>H. Devadoss</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>6.5.79</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>H. Devadoss</i>		22e. ADDRESS <i>Provident Hospital</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6/11/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Wm C March F/H</i>		ADDRESS <i>1101 E. North Ave.</i>		25a. DATE REC'D BY REGISTRAR <i>JUN 8 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Patrick McBrady</i>			

C O L L E C T



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		M	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		June 23, 1979					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		Aug. 15, 1911		67		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Md.		U.S.A.				Baltimore City			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Providence Hospital		Milling		Factory			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Carroll		Sykesville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Main St.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Thomas		Ruth		No		213 03 7557		Gertrude Smith Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CHRONIC OBSTRUCTIVE Lung disease.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4292		DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) ASCVD, arteriosclerotic cardiovascular disease							
		DUE TO, OR AS A CONSEQUENCE OF							
		(c) R/o Bronchogenic Carcinoma Lung							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
RECENT Cerebrovascular Accident with Right Monoplegia.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
NA		NA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
NA		NA 19		NA					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
NA		NA		NA					
22a. I certify that (I) (the hospital) attended the deceased from above the deceased at on 6/23 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
Laurent Pierre		MD		6/25/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
LAURENT PIERRE - PHILIPPE		238N Carey St Baltimore Md 21223							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		6-26-79		Mt. Zion Cemetery		Upper Falls Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Harry W. Haight		Sykesville, Md.		JUL 2 1979		Harry McCready			

BP

Franklin D. Roosevelt  
U.S.A.  
The White House  
Washington, D.C.  
Dear Mr. President

Thank you very much for the  
information received from you  
regarding the situation in  
China.

I am sure that the American  
people will be very interested  
in the progress of the  
negotiations.

Very truly yours,  
ELEANOR ROOSEVELT  
JUL 2 1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 13967	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
			Agnes Jane Brown			6 20 79			2 <sup>00</sup> A M		
3 SEX Female			4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 6 1910		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado			7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10 CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Maryland Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY ---		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. COUNTY Balto.		13c. CITY OR TOWN Balt		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7914 Knollwood Rd. 21204		
14 FATHER'S NAME FIRST MIDDLE LAST George W. Stone			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flossy Gertrude Ashburn			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No ---			16b. SOCIAL SECURITY NO. 216-09-4332		
			17 INFORMANT ADDRESS 21105 Rev. Raymond G. Mull, 21502 York Rd.								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>congestive heart failure</u> (c) <u>coronary artery disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (1) (this hospital) attended the deceased from 6/19, 1979, to 6/20, 1979, that (1) (we) last saw the deceased alive on 6/20, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
27b. SIGNATURE Ronald J. Ross MD						DEGREE MD			27c. DATE SIGNED 6/20/79		
27d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald J. Ross MD						27e. ADDRESS University Md Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/21/79		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem.			23d. LOCATION Cockeysville, Md. COUNTY STATE			
24. FUNERAL DIRECTOR'S NAME J. E. Lowell Lemmon						25a. DATE REC'D. BY REGISTRAR JUN 21 1979			25b. REGISTRAR'S SIGNATURE [Signature]		

A O C I E A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE REGISTRAR		Item 5 #G533 ph 7/9/79 ph		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		1 3 9 6 8	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR	
ALEXANDER		BROWN						6 27 79 6:59 M	
3 SEX M		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 11 + 8 13		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.			
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY P		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1008 N. ROSEDALE ST	
14 FATHER'S NAME FIRST MIDDLE LAST DAVID		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY L. CLARK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII 220-01-4680		17 INFORMANT OSCAR		ADDRESS ABOSCH M.D.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). 4413		DUE TO, OR AS A CONSEQUENCE OF (b). RUPTURED AORTIC ABDOMINAL ANEURYSM		DUE TO, OR AS A CONSEQUENCE OF (c).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 6-27-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RUPTURED ANEURYSM		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6-24-79, 1979, to 6-27, 1979, that (I) (we) last saw the deceased alive on 6-27, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Oscar Ph...		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-27-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSCAR ABOSCH		22e. ADDRESS RUXTON TOWERS SUITE 208							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/30/79		23c. NAME OF CEMETERY OR CREMATORY KING MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24 FUNERAL DIRECTOR NAME Wm. C. March F/H, 1101 E. North Ave.		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUN 29 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Beatrice Brown			6/22/79			5 <sup>00</sup> P M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS
Female	Black	May 20 13	66			MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
King Geo. Co. Va.	U.S.A.		Baltimore City MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	Provident Hospital			Domestic				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Md.			Baltimore					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Woodson Walker			Annie Mae Smith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
No			212-14-8749			Mr. Joseph Brown 1029 N. Bentalon St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> <u>436 -</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>6/11</u> , 19 <u>79</u> , to <u>6/22</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/22</u> , 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <u>W. H. G. Gout</u>			22c. DATE SIGNED <u>6/22/79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			6-27-79		Md. National Cem.		Prince George County, Md.	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
James A. Morgan & Sons			1701 Laurens			JUN 26 1979		

BP





4 0 0 1 0 0 4

King Geo. Co. Va. U.S.A.  
May 20 1904  
Woodson  
Walker  
Anna  
May 20 1904  
1033 N. Benton St.  
St. Louis, Mo.

James A. Norton & Son  
6-27-12  
National Bank  
Prince George County, Md.



FOR  
STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 3 9 7 0

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2b. DATE KNOWN OF ESTI- MATED		XX	MONTH	DAY	YEAR	2b. HOUR
DOROTHY		L.		BROWN	6		11	19	79		M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	7d. HOUR
FEMALE	BLACK	1 21 29	50 YRS.			6		11	19	79	6:11 P
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Va.		USA				BALTIMORE CITY,		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE CITY		433 Pitman Place									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.				Balto.		YES		433 Pitman Place			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Calvin Brown				Elizabeth McNorton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No				212-26-8812		James Brown		433 Pitman Place			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fatty Liver</b> 5718 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>6/12/79</b>			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Ann M. Dixon, M.D.				111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY	STATE		
Burial		6/16/79		King Memorial Pk.		Baltimore Co., Md.					
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm C March F/H				1101 E. North Ave.		JUN 15 1979		<i>History Building</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

U.S. DEPARTMENT OF JUSTICE



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U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

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U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the certificate be secured within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use in the burial or cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 3 9 7 1	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>Eddie Brown</b>			2a. DATE OF DEATH <b>June 5, 1979</b>			2b. HOUR <b>6:02pm</b>					
3. SEX <b>M</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2-13-1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Buckingham, VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2206 E. North Ave.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Randle Brown</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary E. Dabney</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>228-05-7960</b>		17. INFORMANT ADDRESS <b>Alice R. Burrell - Richmond, Va.</b>						
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic shock</b> <b>410 -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Massive myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary artery disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>several hours</b> <b>1 week</b> <b>undetermined</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Renal failure, hepatic failure, thrombocytopenia</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (he) (this hospital) attended the deceased from <b>5/31/79</b> 19 <b>79</b> , to <b>6/5</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/5</b> 19 <b>79</b> , and that (my) (our) opinion on death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Nancy L. Peter, M.D.</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>June 5, 1979</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Nancy L. Peter, M.D.</b>			22e. ADDRESS <b>The Johns Hopkins Hospital</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>6-11-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. Auburn Cem</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westport Md.</b>			
24. FUNERAL DIRECTOR NAME <b>ELICKSON F.H.</b>			ADDRESS <b>1129 N. CAROLINE</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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Released on 11/11/79 by M.F.O.  
DIVISION OF HEALTH SERVICES, BALTIMORE, MARYLAND 21201

DHMH-16 50M 7/77  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 3 9 7 2 REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <b>PEARLINE BROWN</b>					2a. DATE OF DEATH MONTH <b>6</b> DAY <b>21</b> YEAR <b>1979</b>					2b. HOUR <b>10</b> <sup>44</sup> <b>A</b> <sup>M</sup>		
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>1</b> DAY <b>18</b> YEAR <b>34</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>45</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 74 HRS HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD					
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>1428 N. Bethel St.</b>				
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>								
14. FATHER'S NAME FIRST <b>Nemiah</b> MIDDLE <b></b> LAST <b>Monltrice</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Edith</b> MIDDLE <b></b> LAST <b>Fayall</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b></b>		17. INFORMANT ADDRESS <b>Phila., Pa.</b> <b>Edith Harris 1529 S. Colorado St.</b>						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>INTRACEREBRAL HEMORRHAGE</b> <b>431-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>DIABETES MELITUS</b>												
19a. DATE OF OPERATION <b>MA</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b></b> <b></b> <b></b> <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from <b>6/20</b> , 19 <b>79</b> , to <b>6/21</b> , 19 <b>79</b> , that (1) (we) lost saw the deceased alive on <b>6/21</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>David J. Tolner</b>					DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/21/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID J. TOLNER</b>					22e. ADDRESS <b>601 N. BROADWAY, BALTIMORE, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/26/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Phila., Pa.</b>				
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b> ADDRESS <b>1101 E. North Ave.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1979</b>			25b. REGISTRAR'S SIGNATURE <b>L. H. McElroy</b>				

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		13a-13e #G533 7/16/79 ph		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH		13973	
1. DECEASED NAME (TYPE OR PRINT) <b>SHELTON BROWN</b>				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 20 19 79</b>		2b. HOUR <b>1:22</b>	
3. SEX <b>male</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 18 61</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>18</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD <b>6 20 19 79</b>	7d. HOUR <b>A M</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>		13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>851 George St.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Melvin Brown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Brown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>851 George Street Apt, 12G</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of chest with complications</b> <b>9654</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR M. MONTH DAY YEAR <b>11:05 2 24 79</b> P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>shot by assailant</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>2nd floor bedroom</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>823 George Street Baltimore, Md.</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Margarita A. Korell</b>		TITLE (SPECIFY) <b>Assistant</b>		MEDICAL EXAMINER		DATE SIGNED <b>6/20/79</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>		ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-23-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Randalltown, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>James A. Morton &amp; Sons</b> ADDRESS <b>1701 Laurens</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 25 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony A. Brady</b>	

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1961 Jan 13 10 10

Mr. J. Edgar Hoover, U.S.A.

Washington, D.C.

My dear Mr. Hoover:

851 George Street Apt. 120

San Francisco, Calif.

Dear Mr. Hoover:

I am writing you to inform you that

George A. Brown 1901 January 13 1961  
King New York  
San Francisco, Calif.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH13974  
REG. NO.

1- FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		FIRST Thelma		MIDDLE H/		LAST Brown		2b. DATE KNOWN OF DEATH ESTIMATED		MONTH 6		DAY 28		YEAR 1979		2d. HOUR 4:15P					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov 11, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 30 1979													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD											
10. CITY OR TOWN OF DEATH Baltimore City				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2111 E. Lombard St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor				12b. KIND OF BUSINESS OR INDUSTRY Box Co.											
13a. STATE Maryland				13b. COUNTY -----				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 2111 E. Lombard St.							
14. FATHER'S NAME FIRST MIDDLE LAST Henry Love				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Brehm																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----				17. INFORMANT Helen White				ADDRESS 1606 Joplin St. 21224											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) Deputy Chief				MEDICAL EXAMINER				DATE SIGNED 7/1/79											
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 3, 79				23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Belair Harford Md											
24. FUNERAL DIRECTOR NAME Dippel Brothers, Inc.				ADDRESS 7110 Belair Rd. 21206				25a. DATE REC'D BY REGISTRAR JUL 5 1979				25b. DATE REC'D BY REGISTRAR <i>[Signature]</i>											

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ANNA CONSTANCE BRUKIEWA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 26 1979</b>			2b. HOUR M <b>AM</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 22 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>621 S. BELNORD AVE.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>621 S. BELNORD AVE.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALBERT MRYNCZA</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA DZIERWINSKI</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO <b>216 09 1966A</b>		17. INFORMANT ADDRESS <b>MR. ERNEST BRUKIEWA 621 S. BELNORD AVE</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Carcinoma of the liver**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**3 1/2 months**

**1552**  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>5-8</b> , 19 <b>79</b> , to <b>5-7</b> , 19 <b>79</b> , that (I) <b>did</b> not saw the deceased alive on <b>5-7</b> , 19 <b>79</b> , and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>was</b> <b>not</b> did not view the body after death.							
22b. SIGNATURE <b>Melito M. Torres</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6-28-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Melito M. Torres, M.D.</b>				22e. ADDRESS <b>441 S. Ellwood Ave. Balto., Md. 21224</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/30/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CHURCH</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>	
24. FUNERAL DIRECTOR NAME <b>RAYMOND L. KACZOROWSKI</b>				ADDRESS <b>2525 FLEET ST.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 3 1979</b>	
						25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 3 9 7 6

1. DECEASED NAME (TYPE OR PRINT) <b>Robert Brunner</b>				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 23 1979</b>				2b. HOUR M <b>7:25P</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 2, 1948</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>31</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 24 1979</b>		2d. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1814 St. Paul Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Councillor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Penal</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1814 St. Paul Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>David Brunner</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bella Pogrebisky</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>062-38-3588</b>		17. INFORMANT ADDRESS <b>David Brunner Andover D-98 W. Palm Beach</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>7503</b> IMMEDIATE CAUSE (a) <b>Acute doxepine intoxication</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 6/23/ 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>self-ingested</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1814 St. Paul St. Baltimore Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Margareta A. Korell</b>		TITLE (SPECIFY) <b>Assistant</b>		M.D. MEDICAL EXAMINER		DATE SIGNED <b>6/25/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>		ADDRESS <b>111 Penn St. Balto., MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>6/26/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ambrose Funeral Home 1328 Sulphur Spring Rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Brunner</b>			



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FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MAMIE V. BUDD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 19 79</b>			2b. HOUR <b>M</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUG. 16, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MT. AIRY, MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4415 CRADDOCK AVENUE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UNEMPLOYED</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4415 CRADDOCK AVENUE</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY RIDGELY</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SUSAN JANE RIDGELY</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO.</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-0533370</b>		17. INFORMANT ADDRESS <b>MR. GARNETT BUDD 2548 ARUNAH AVENUE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>possible acute myocardial infarction</b> 410- DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 19 79</b> , to <b>6/17 79</b> , that (I) (we) lost saw the deceased alive on <b>6/17 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Stacy R. Poan</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/20/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stacy R. Poan</b>			22e. ADDRESS <b>St. Joseph Hospital</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>6/22/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>KING MEMORIAL PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>RANDALLSTOWN, MARYLAND</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>LEROY O. DYETT 4600 LIBERTY HEIGHTS AVENUE</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 21 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert Halburdy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ALBERT F. BUETTNER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 22 1979</b>		2b. HOUR <b>6 35 A M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 1, 1912</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>67 YRS</b>		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Balt. City Policeman</b>		
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS <b>Balt., Md. 21213 3326 Kenyon Avenue</b>				
13b. COUNTY <b>Maryland</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Buettner</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lena Krueger</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-18-0489</b>		17. INFORMANT <b>Wife:</b> <b>Gertrude A. Buettner</b> ADDRESS <b>Balt., Md. 21213 3326 Kenyon Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia, aspiration</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>edema level of consciousness + pulm.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>subarachnoid hemorrhage cerebral</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 days</u> <u>10 days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>① anterior communicating artery aneurism</u>						
19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NR</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>June 11</u> , 19 <u>79</u> , to <u>June 22</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>June 22</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.						
22b. SIGNATURE <u>Lalah Newbrough MD</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4-22-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LALAH NEWBROUGH</b>		22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jun 25 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>				
24a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>		24b. REGISTRAR'S SIGNATURE <u>Jeffrey McBrody</u>				

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 3 9 7 9

1. DECEASED NAME (TYPE OR PRINT) <b>MARY ANGELA BUHL</b> <i>Mary A Buhl</i>		2a. DATE OF DEATH MONTH DAY YEAR <b>6 12 79</b> <i>6 12 79</i>		2b. HOUR <b>12:44A</b> <i>12:44A</i>	
3. SEX <b>FEMALE</b> <i>F</i>		4. RACE <b>WHITE</b> <i>A</i>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 26 12</b> <i>5 26 12</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>md.</b> <i>md.</i>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> <i>A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Baltimore City</b> <i>Baltimore City</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial</b> <i>Union Memorial</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> <i>Baltimore City</i> MD.	
13a. STATE <b>Maryland</b> <i>Md.</i>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b> <i>Baltimore</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph W.L. Evans</b> <i>Joseph W.L. Evans</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine L. Dunn</b> <i>Catherine L. Dunn</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> <i>No</i>		16b. SOCIAL SECURITY NO. <b>800-03-1705</b> <i>800-03-1705</i>		17. INFORMANT ADDRESS <b>George L. Buhl 4604 Seifert Ave.</b> <i>George L. Buhl 4604 Seifert Ave.</i>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Pulmonary Embolus</b> <i>4290</i> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocarditis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <i>2 hrs.</i> <b>2 months</b> <i>2 months</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION <b>5/9/79</b> <i>5/9/79</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Insertion of Permanent Pacemaker</b> <i>Insertion of Permanent Pacemaker</i>		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b></b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b></b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK <b></b>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b></b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/16</b> , 19 <b>79</b> , to <b>6/12</b> , 19 <b>79</b> , that (I) <b>last</b> saw the deceased alive on <b>6/12</b> , 19 <b>79</b> , and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>we</b> (did) <b>not</b> view the body after death.					
22b. SIGNATURE <b>Alan B. Cohen</b> <i>Alan B. Cohen</i>		DEGREE <b>ATTENDING MEDICAL PHYSICIAN</b> <i>ATTENDING MEDICAL PHYSICIAN</i>		22c. DATE SIGNED <b>6/12/79</b> <i>6/12/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alan B. Cohen</b> <i>Alan B. Cohen</i>		22e. ADDRESS <b>Union Memorial Hospital</b> <i>Union Memorial Hospital</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b> <i>Cremation</i>		23b. DATE <b>June 15, 1979</b> <i>June 15, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b> <i>Green Mount</i>	
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc. Baltimore, Md.</b> <i>Leonard J. Ruck, Inc. Baltimore, Md.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b> <i>Baltimore Md.</i>		25a. DATE REC'D. BY REGISTRAR <b>JUN 13 1979</b> <i>JUN 13 1979</i>	
25b. REGISTRAR'S SIGNATURE <b>Patricia J. Cohen</b> <i>Patricia J. Cohen</i>					

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13449

NAME

ADDRESS

CITY

WHITE

STATE

Housewife

2417 Shannon Drive

XX

Beltsville

Maryland

Age

1

Occupation

Housewife

Married

Female

George W. Smith 4804 Belmont Ave.

800-07-1705

No

Mr.

Baltimore

One 101-8222 Mount

Greenland

Leopold J. Hock 100 Baltimore, Md.

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TO HOSPITAL: ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 3 9 8 0

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES BUNGER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 1 1979</b>		2b. HOUR M
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 11 1913</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>214 S. MADEIRA ST.</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>214 S. MADEIRA ST.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HENRY BUNGER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA CLEMENS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>MRS THELMA MYERS 214 S. MADEIRA</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Arrest</b> <b>1629</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Poorly Differentiated Bronchogenic Carcinoma</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>G. Werner MD</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>6/4</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. Werner MD</b>		22e. ADDRESS <b>Balto. City Hospital</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>6/5/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAWN CEM</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>
24. FUNERAL DIRECTOR NAME <b>Raymond L. Kaczorowski</b>		ADDRESS <b>2525 FLEET</b>	25a. DATE REC'D. BY REGISTRAR <b>JUN 5 1979</b>
		25b. REGISTRAR'S SIGNATURE <b>P. J. Healy</b>	

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Kachene Burman</b>						2a DATE OF DEATH MONTH DAY YEAR <b>6/28/79</b>		2b HOUR <b>8:15 P M</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>6/23/90</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTO. CITY HOSPITALS</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AT HOME</b>		12b KIND OF BUSINESS OR INDUSTRY <b>—</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD.</b>		13b COUNTY <b>BALTO.</b>		13c CITY OR TOWN <b>ROSEDALE</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>339 Elinor Ave. 21236</b> <b>1812 HANFORD RD. 21237</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK P. RAY</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA A. ANGEL</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b SOCIAL SECURITY NO. <b>—</b>		17 INFORMANT ADDRESS <b>R.C. JETT, JR, 1812 HANFORD RD 21237</b>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>436-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Christopher F. Jett</b>				DEGREE <b>B. C. H.</b>				22c DATE SIGNED <b>6/28/79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS <b>B. C. H.</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>2 JULY 79</b>		23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE CEMETERY</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD. 21213</b>			
24 FUNERAL DIRECTOR NAME <b>CECCHINI FUNERAL HOME, BALTO. MD 21206</b>				25 DATE REC'D BY REGISTRAR <b>JUL 2 1979</b>		25b REGISTRAR'S SIGNATURE <b>F. Jett</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Hubert V BURKE			2a. DATE OF DEATH MONTH DAY YEAR 6-15-79			2b. HOUR 1:40 M		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 25 17		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.		
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY --		13c. CITY OR TOWN Balto.		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 4304 Springdale Ave.				
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 381-17-0525		17. INFORMANT ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> <u>2760</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe metabolic Acidosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (X) (this hospital) attended the deceased from <u>6-14-1979</u> to <u>6-15-1979</u> , that (I) (we) last saw the deceased alive on <u>6-15-1979</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>H Devadoss</u>				DEGREE MD		22c. DATE SIGNED <u>6/15/79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>H Devadoss</u>				22e. ADDRESS <u>Provident Hospital</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE <u>6-21-79</u>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR <u>JUN 27 1979</u>		
				25b. REGISTRAR'S SIGNATURE <u>Anthony M. Brady</u>				

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UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

(M)

State	Blind	SS	17	62
City	USA	X		Latino City
Latino	Providence Hosp.			
Lat.	Latino			1305 Springdale Ave.

361-17-0825

OFFICE OF THE ATTORNEY GENERAL  
WASHINGTON, D.C.

RECEIVED

RECEIVED  
JAN 17 1962

Latino City

JAN 17 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN EDWARD BURKE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-14-79</b>			2b. HOUR <b>12:45 pm</b>			
3 SEX <b>MALE</b>		4 RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-25-1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>110 Mellor Avenue 21228</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Florian Borkowski</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosie Augustinyak</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>212-16-0031</b>		17. INFORMANT ADDRESS <b>Mrs. Mary E. Burke Same as # 13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> <b>1519</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>TERMINAL CARCINOMA OF STO MACH</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>&amp; Metastatic to Liver.</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>—</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <b>JUNE 4</b> , 19 <b>79</b> , to <b>JUNE 14</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>JUNE 14</b> , 19 <b>79</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <b>XX</b>									
22b. SIGNATURE <b>Paiteon Sritulandh</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>6/14/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAITEON SRITULANDH.</b>					22e. ADDRESS <b>900 CATON AVE. BALTIMORE, MD. 21229</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/16/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>MacNabb Funeral Home</b>					ADDRESS <b>Catonsville, Md. 21228</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 18 1979</b>		25b. REGISTRY YEAR'S

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Henry E. Burley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 26, 1979</b>			2b. HOUR <b>9:30 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 16, 1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>50</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Richmond, England - U.S.A.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electronic Engineer-house</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>204 Sanford Avenue</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Basil Burley</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Robgen</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-38-7048</b>		17. INFORMANT <b>Catonsville, Md. 21228.</b> <b>Mrs. Olive Anne Burley-204 Sanford Ave</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> <b>4254</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic ischemic myocardiopathy</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> <b>5 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Emphysema</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <b>9/19/60</b> 19 <b>60</b> to <b>6/26</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/15</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE <b>Irwin H. Moss, M.D.</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>6/28/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Irwin H. Moss, M.D.</b>				22e. ADDRESS <b>11065 Little Patuxent Parkway Columbia, Maryland 21044</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>6/28/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery-Baltimore, Maryland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Sterling Funeral Estate</b> <b>736 Edmondson Ave.</b> <b>Catonsville, MD 21228</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 2 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia A. Burley</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

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1970

June 20, 1970

London

Henry E.

May 18, 1970

White

Baltimore City

x

Right of London - U.S.A.

Electronic Engineering

Baltimore - St. James Hospital

201 Seaford Avenue

Ad. Baltimore Catonsville x

London

London

Burke

B all

Catonsville, Md. 21224

217-38-20487, Clive King Burke - London

no



Continuation of 6/25/70 London Mary to Henry-Baltimore, Baltimore

Continuation of 6/25/70

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.			7 9 1 3 9 8 5			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAGGIE BURRELL						7a. DATE OF DEATH MONTH DAY YEAR JUNE 21, 1979			7b. HOUR 3:30P M
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 24 85		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Unkn			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unkn			13e. STREET ADDRESS 2248 E. North Ave.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-03-5965		17. INFORMANT ADDRESS Clauda Lee Kiah 2248 E. North Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 585- IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>chronic renal failure</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes 4 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>June 4</u> , 19 <u>79</u> , to <u>June 18</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>June 18</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard J. Rodeheffer			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/21/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard J. Rodeheffer			22e. ADDRESS Johns Hopkins Hospital Baltimore						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/26/79		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co. Md.		
24. FUNERAL DIRECTOR NAME Wm C March F/H			ADDRESS 1101 E. North Ave.			25a. DATE REC'D. BY REGISTRAR JUN 26 1979		25b. REGISTRAR'S SIGNATURE R. J. Brady	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 3 9 8 6	
1. FOR STATE REGISTRAR				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD E BUSH			2a DATE OF DEATH MONTH DAY YEAR 6 3 79		2b HOUR 7:07 PM
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR 07 02 86		6 AGE (IN YEARS LAST BIRTHDAY) 92 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10 CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GLASS WORKER	12b KIND OF BUSINESS OR INDUSTRY CARR-LOWREY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND		13b COUNTY HOWARD	13c CITY OR TOWN ELKRIDGE	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM BUSH		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY RICKS			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW I 215-01-9591		17 INFORMANT ADDRESS GENEVA M. COATES, 1005-2 LEEDS AVENUE, APT. L	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4440 <u>CARDIO-RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Thrombosis of Abdominal Aorta</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a DATE OF OPERATION 6-3-79		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Occlusion of the Abd. Aorta		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 6-3-79 to 6-3-79, that (I) (we) last saw the deceased alive on 6-3-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE M. H. Budeir		DEGREE M.D.		22c DATE SIGNED 6-3-79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) M. H. Budeir		22e ADDRESS 900 CATON AVE. BALTIMORE, MD. 21229			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 06-06-79		23c NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY	
24 FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.,		24b ADDRESS 21229 4107 WILKENS AVE.		25a DATE REC'D. BY REGISTRAR JUN 6 1979	
25b REGISTRAR'S SIGNATURE P. J. [Signature]					

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FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

13987

1. DECEASED NAME (TYPE OR PRINT) <b>EMMA L. BUTLER</b>			2a. DATE OF DEATH MONTH <b>6</b> DAY <b>10</b> YEAR <b>79</b>			2b. HOUR <b>5</b> MIN <b>55</b> AM					
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>6</b> DAY <b>12</b> YEAR <b>82</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>96</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2114 N. SMALLWOOD ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UNKNOWN</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2114 N. SMALLWOOD ST.</b>			
14. FATHER'S NAME FIRST <b>AMOS</b> MIDDLE <b>POWELL</b> LAST <b>POWELL</b>				15. MOTHER'S MAIDEN NAME FIRST <b>ELIZABETH</b> MIDDLE <b>RICHARDSON</b> LAST <b>RICHARDSON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>212-74-7801</b>		17. INFORMANT ADDRESS <b>MEDICAL RECORDS</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARRHYTHMIA</b> <b>4148</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD - OLD MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SENILE DEMENTIA</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b> <b>YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>SENILE DEMENTIA</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4-07</b> 19 <b>78</b> P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>PRESENT</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>2025 W. FAYETTE ST. BALTO., MD. 21223</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>4-07</b> 19 <b>78</b> , to <b>PRESENT</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>5-17</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Oscar E. Fernandez M.D.</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6-10-79</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>OSCAR E. FERNANDINI</b>						22e. ADDRESS <b>2025 W. FAYETTE ST. BALTO., MD. 21223</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>6-14-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. AUBURN</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>			
24. FUNERAL DIRECTOR NAME <b>JAMES A. MORTON &amp; SONS</b> ADDRESS <b>- 1701 LAURENS ST.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 13 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony A. Brady</b>			

16661



*[Faint, mostly illegible handwritten text, possibly in Devanagari script, covering the majority of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		7 9		1 3 9 8 8		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) GLOVER DELL BUTLER			2a. DATE OF DEATH 6/20/79			2b. HOUR 11 PM			
3 SEX ♀		4 RACE BLACK		5. DATE OF BIRTH 4 16 06		6 AGE (IN YEARS (LAST BIRTHDAY)) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNK		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH Balt City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lived at home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ---		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD		13b. CITY OR TOWN Balt.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 1964 W. FRANKLIN ST.			
14. FATHER'S NAME FIRST MIDDLE LAST UNK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-30-7309		17. INFORMANT			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 0389 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pneumonia</u> (c) <u>Sepsis Presumed</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Probable Sepsis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 20, 1979</u> to <u>JUNE 20, 1979</u> that (I) (we) lost saw the deceased alive on <u>JUNE 20, 1979</u> and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. <u>1:30 PM</u>									
22b. SIGNATURE Joseph A. Petrozzo MD		22c. ADDRESS 1624 W. FRANKLIN ST.		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Petrozzo MD		22e. DATE SIGNED 6/20/79			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-25-79		23c. NAME OF CEMETERY OR CREMATORY Arbutus		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME James A. Morton & Sons				ADDRESS 1701 Laurens		25a. DATE REC'D. BY REGISTRAR JUN 25 1979		25b. REGISTRAR'S SIGNATURE Hickey McCreedy	

88131

Albion

James H. Hutton & Sons 1871

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

13989

1 DECEASED NAME (TYPE OR PRINT) <b>James Jackson Caldwell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 4, 1979</b>			2b. HOUR PM <b>11:15 M</b>				
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8/9/16</b>		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN <b>62</b> YRS.		7 IF UNDER 1 YEAR IF UNDER 24 HRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.				
10 CITY OR TOWN OF DEATH <b>Balto. City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>US PHS Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RET-Army</b>		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE <b>MD</b>			13b COUNTY <b>Balto</b>		13c CITY OR TOWN <b>Dundalk</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>1813 Belle Ave.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>William Caldwell</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Wallace</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b SOCIAL SECURITY NO. <b>1942-69</b>		17 ADDRESS <b>1813 Belle Ave. Balto. MD 21222</b>					
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of lung, rt.</b> DOE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Terminal</b> <b>5 Mos</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 28, 1979</b> to <b>June 4, 1979</b> , 19____, that (I) (we) lost saw the deceased alive <b>June 4 1979</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>D. Bowman MD</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>June 5, 1979</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D.F. Bowman</b>					22e. ADDRESS <b>3100 Wyman Park Drive</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>6/8/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>				
24 FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>					24b. ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Ruthy Kethley</b>	

BP

1 3 0 8 4

June 4, 1978 01:15

Male Caucasian 8/9/16  
Pa. 18A  
Baltimore City

Baltimore City US PMS Hospital  
MD Baltimore  
1618 Belle Ave.

William Caldwell  
Catherine  
Wallace  
1942-88 170 11 0755 US MC Hospital

June 4 1978 May 28, 1978 June 4, 1978

June 3, 1978

June 3, 1978

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR STATE REGISTRAR		7 9 1 3 9 9 0	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELSIE R. CALLAHAN		2b. DATE OF DEATH MONTH DAY YEAR June 29, 1979 4 <sup>00</sup> P.M.	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Feb. 22, 1913	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	6. AGE (IN YEARS LAST BIRTHDAY) 66 years YRS.	8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hospital	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR LAST YEAR OR LAST 12 MONTHS) Cook		12b. KIND OF BUSINESS OR INDUSTRY Balto., Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Baltimore	
13c. CITY OR TOWN Arbutus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX	
13e. STREET ADDRESS 1241 Seven Oaks Road 21227			
14 FATHER'S NAME FIRST MIDDLE LAST Samuel Lindamood		15 MOTHER'S MAIDEN NAME FIRST MIDDLE Nettie Jordan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 218-03-2618	
17 INFORMANT Mr. Edward T. Callahan, 1241 Seven Oaks Rd.		ADDRESS Balto., Md. 21227	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Oat Cell Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 34 weeks 14 mos.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from May 1978, to June 1979, that (I) (we) last saw the deceased alive on June 29 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Janice P. Dutcher MD		22c. DATE SIGNED 6/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Janice P. Dutcher MD		22e. ADDRESS BCRC, Univ. of Md Hosp	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/3/79	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Howard County, Maryland	
24 FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave		25a. DATE REC'D. BY REGISTRAR JUL 2 1979	
25b. REGISTRAR'S SIGNATURE [Signature]			

BP



0 9 4 2 1

UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF  
WASHINGTON, D. C.

MEMORANDUM FOR THE CHIEF OF STAFF  
SUBJECT: [Illegible]

1. [Illegible]  
2. [Illegible]  
3. [Illegible]

4. [Illegible]  
5. [Illegible]  
6. [Illegible]

7. [Illegible]  
8. [Illegible]  
9. [Illegible]

10. [Illegible]  
11. [Illegible]  
12. [Illegible]

13. [Illegible]  
14. [Illegible]  
15. [Illegible]

16. [Illegible]  
17. [Illegible]  
18. [Illegible]

19. [Illegible]  
20. [Illegible]  
21. [Illegible]

22. [Illegible]  
23. [Illegible]  
24. [Illegible]

25. [Illegible]  
26. [Illegible]  
27. [Illegible]

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ALBERT LEROY CALLENDER</b>			2a. DATE OF DEATH MONTH <b>06</b> DAY <b>06</b> YEAR <b>79</b>		2b. HOUR <b>12:30 P.M.</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>19</b> YEAR <b>06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2132 WILKENS AVENUE, 21223</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BUS DRIVER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>GEORGE</b> MIDDLE <b>A.</b> LAST <b>CALLENDER</b>		15. MOTHER'S MAIDEN NAME FIRST <b>LILLY</b> MIDDLE <b>MELCHOR</b> LAST <b>MELCHOR</b>		13e. STREET ADDRESS <b>2132 WILKENS AVENUE, 21223</b>		TRANSIT AUTH.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-10-1433</b>		17. INFORMANT <b>LUELLA M. CALLENDER, 2132 WILKENS AVENUE</b>		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous cell CA</u> 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Samir</i>		DEGREE <i>(M.D.)</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/7/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SAMIR NAJJAR, M.D.</b>		22e. ADDRESS <b>900 CATON AVENUE, BALTIMORE, MD. 21229</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>06-11-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CREM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.,</b>		ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 8 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Anthony McBrady</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1981



## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Cecelia Camper</b>			2a. DATE OF DEATH Month Day Year <b>6 / 4 / 79</b>			2b. HOUR M <b>1</b>				
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>6/12/94</b>		6. AGE (In years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto. City</b> Md.				
10. CITY OR TOWN OF DEATH <b>Balto.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>2402 Liberty Height</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. CITY <b>City</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2402 Liberty Hgt. Ave.</b>	
14. FATHER'S NAME First Middle Last <b>Ellison Keith</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Keith</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO. <b>110-03-8050</b>		17. INFORMANT Address <b>James Camper 2402 Liberty Hgt. Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE Heart Failure</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>OLD Age</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>MAL NUTRITION</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on <b>2/11/79</b> 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.										
22b. SIGNATURE <b>I. Singh</b>					DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>I. Singh M.D.</b>					22e. ADDRESS <b>2301 Old Annapolis Rd.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>6/11/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>			23d. LOCATION (City or Town) (County) (State) <b>A.A. Co. Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Charles A. Rice 1300 Eutaw Pl.</b>					25a. REC'D BY REGISTRAR DATE <b>JUN 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. IF THE DEATH IS SUSPECTED TO BE A SUICIDE, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. IF THE DEATH IS SUSPECTED TO BE A SUICIDE, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13993  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BERNARD L. CANBY</b>			20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 26 19 79</b>			21. HOUR <b>4:30 P</b>
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 22, 1915</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 26 19 79</b>	21. HOUR <b>4:30 P</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2303 Pentland Drive</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>City</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2303 Pentland Drive</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Winfield Canby</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Bailey</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-03-0021</b>		17. INFORMANT ADDRESS <b>Peggy H. Canby, Same As #13e</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>6/27/79</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>		ADDRESS <b>111 Penn Street</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-29-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard Md.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. Towson, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Howard</i>



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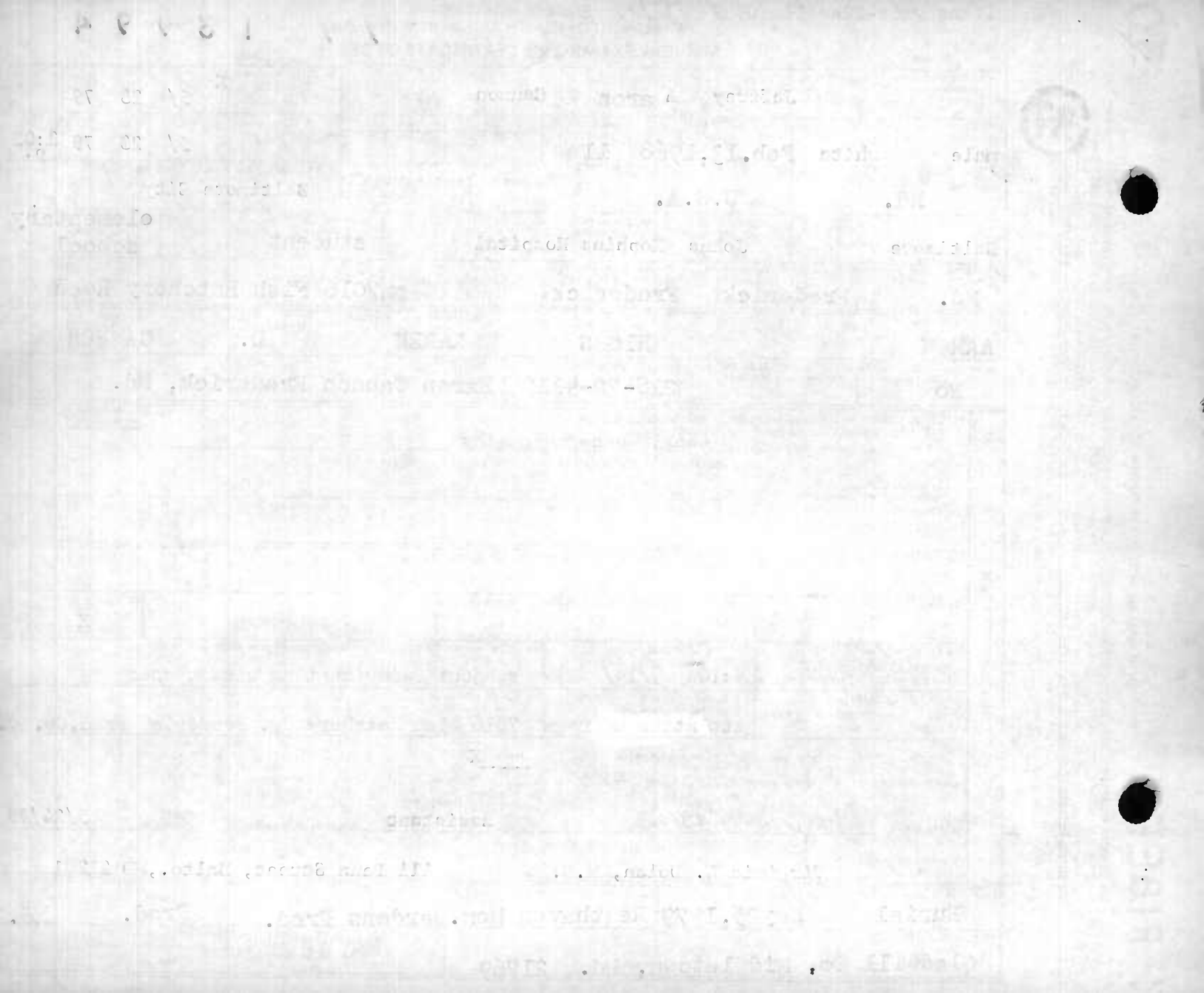
Items #10a-22a Film G532 6/13/79 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

13994

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
Jeffrey A aron Cannon								5/ 23 19 79								M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		2d. HOUR			
male	white	Feb. 13, 1968		11 YRS.						5/ 23 19 79						2:05 p.m.			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Md.		U.S.A.				Baltimore City													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)													
Baltimore		Johns Hopkins Hospital				student elementary school													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md.		Frederick		Frederick		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7016 Fish Hatchery Road											
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST									
AARON				RIGGS		KAREN		D.		CANNON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		218-72-4119		Karen Cannon Frederick, Md.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) <u>Anoxic encephalopathy</u>																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b) <u>hanging</u>																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c) _____																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?			
																YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				5:10 P.M. 5/19/ 19 79				subject experimenting with nooses											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				COUNTY				STATE			
				attie over garage				7016 Fish Hatchery Rd.				Frederick				Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
Virginia L. Dolan M.D.				Assistant				5/24/79											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Virginia L. Dolan, M.D.				111 Penn Street, Balto., MD 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				COUNTY		STATE	
Burial				May 25, 1979				Resthaven Mem. Gardens				Fred.						Md.	
24. FUNERAL DIRECTOR				NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Gladhill Co.				Middletown, Md.				21769				MAY 28 1979				[Signature]			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 60M 1/75  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 13995	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>KARL G. CARNES</b>				2a DATE OF DEATH MONTH DAY YEAR <b>6 11 79</b>		2b HOUR <b>11:00 A.M.</b>			
3 SEX <b>MALE</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>9 8 03</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS <b>75</b>		7 IF UNDER 1 YEAR MONTHS DAYS 8 UNDER 24 HRS. HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>					
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hosp</b>				12a MAJOR OCCUPATION (TYPE OF WORK DURING LIFE) <b>Maintenance Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>G.M.</b>			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>1704 Woodland Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lloyd M. Carnes</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruhuna Basham</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b SOCIAL SECURITY NO. <b>216-10-7570</b>		17. INFORMANT ADDRESS <b>1704 Woodland Drive Balto. MD 21222</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4292 Cardio pulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>3-5</b> , 19 <b>79</b> , to <b>6-11</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6-11</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <b>6-11-79</b>	
22b. SIGNATURE <b>R. Chen-Tan</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6-11-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. CHEN-TAN</b>				22e. ADDRESS <b>Baltimore City Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/14/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>				ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>			

SECRET



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 1 3 9 9 6								
1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH							REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST LOUISE		MIDDLE S.		LAST CAROLINA		2a. DATE OF DEATH		MONTH 06 / 27 / 79		DAY 12		YEAR 25		HOUR PM	
3 SEX FEMALE			4 RACE BLACK		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS								
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17 INFORMANT (Son)			ADDRESS										
No.			248-26-0899		Mr. Leroy Carolina			5133 The Alameda										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY																		
IMMEDIATE CAUSE (a)										27 hrs								
DUE TO, OR AS A CONSEQUENCE OF										years								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																		
DUE TO, OR AS A CONSEQUENCE OF																		
(c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																		
Juv onset P.M. Insulin dependent; Ketotic coma																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED												
			HOUR A.M. MONTH DAY YEAR															
			P.M.															
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION												
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET			CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 6/1, 1979, to 6/27, 1979, that (I) (we) last saw the deceased alive on 6/27, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED									
Gregory L. Walker MD			M.D.						6/27/79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
GREGORY L. WALKER M.D.			UNION MEMORIAL HOSPITAL															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION									
Burial			7/3/79			Mt. Calvary Cemetery			Baltimore, Maryland									
24 FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE												
NAME			ADDRESS															
LEROY O. DYETT & SON F.H., INC.			4600 Liberty Hgts.			JUN 29 1979			R. H. H. H.									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 9 1 3 9 9 7				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY C CARPER					2a. DATE OF DEATH MONTH DAY YEAR 6 20 79			2b. HOUR 1:50 P.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 4 - 16 - 18 98		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MONTGOMERY		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S. BALTIMORE GEN. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY Pipefitter	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1443 PATRISCO ST	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM C CARPER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHARLE MILLER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-03-8166		17. INFORMANT ADDRESS Mrs. Alice M. Carper, Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 0389 POSS. SEPTIC. POSS. GI BLEEDING DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): CHRONIC OBSTRUCTIVE PULMONARY DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6-25, 1979, to 6-20, 1979, that (I) (we) lost saw the deceased alive on 6-20, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Lydia M. Jumanoy, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6-20-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LYDIA M. JUMANOY, M.D.				22e. ADDRESS S. BALTO. GEN. HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 23, 1979		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cent.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS McUllly Funeral Home, 130 E. Font Ave. Balto. Md.				25a. DATE REC'D. BY REGISTRAR JUN 22 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

9 9

2302 BP



1961 41

(14)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13998

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTIMATED		2d. HOUR	
GERALDINE F. CARRINGTON		6 1 19 79		7:20	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
female	negro	7 6 15	63 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	8. NEVER MARRIED	8. WIDOWED	8. DIVORCED
Md.	USA				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	Church Home Hospital				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md.		Balto.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	12 N. Waldo Ct.	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.			
Edward Carrington	Annie Williams	218-16-2319			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
No	218-16-2319	Constance Elam 1042 McDonogh St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Ann M. Dixon, M.D.		Assistant		6-2-79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
		111 Penn St.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	6/7/79	Mt. Auburn Cem.	Balto., Md.		
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Wm C. March F/H	1101 E. North Ave.		JUN 7 1979		

0000 BP

2953

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Item 8 533 7/23/79 gj

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Lawrence W. Carroll SR.</b>			2a. DATE OF DEATH MONTH <b>6</b> DAY <b>27</b> YEAR <b>79</b>			2b. HOUR <b>9:12P</b>			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>27</b> YEAR <b>06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BALTO. CITY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>921 Courtney Rd.</b>	
14. FATHER'S NAME FIRST <b>JAMES R.</b> MIDDLE <b>Carroll</b> LAST				15. MOTHER'S MAIDEN NAME FIRST <b>DORA</b> MIDDLE <b>EINOFF</b> LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>352-07-1955</b>		17. INFORMANT ADDRESS <b>MILDRED M. CARROLL SAME 21227</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b> sudden</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>acute MI 1968. Severe Angina over years.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <b>the hospital</b> attended the deceased from <b>1-18-63</b> 19 to <b>6-27-79</b> 19, that (I) <b>have</b> lost saw the deceased alive on <b>7-12-76</b> 19, and that in (my) <b>best</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>we</b> did <b>not</b> view the body after death.									
22b. SIGNATURE <b>John F. Schaefer MD</b>				DEGREE			22c. DATE SIGNED <b>6/28/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN F. SCHAEFER M.D.</b>				22e. ADDRESS <b>5558 BALTO. NATL. PIKE 21228</b>					
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>6-30-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEM.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>		
24. FUNERAL DIRECTOR NAME <b>FARLEY F.H.</b> ADDRESS <b>6601 FRED. AVE. CATONSVILLE</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 2 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 0 0 0

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>MARY W. CARROLL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-30-79</b>			2b. HOUR <b>7.10 P</b>				
3 SEX <b>F</b>		4 RACE <b>N</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8-2-76</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LUTHERAN HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>21217 1138 N. Stricker St.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>HENRY YOUNG</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY RANSOME</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. <b>216-01-9370</b>		17. INFORMANT ADDRESS <b>EVA Young Tappahannock, Virginia</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO - RESPIRATORY ARREST</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>GANGRENE (R) Leg.</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>GANGRENE R LEG</b>										
19a. DATE OF OPERATION <b>6-29-79</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gangrene (R) foot</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <b>6-28-79</b> to <b>6-30-79</b> , that (I) (we) lost the deceased alive on <b>6-30-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>JRB</b> DEGREE						22c. DATE SIGNED <b>6-30-79</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR BHAT</b>						22e. ADDRESS <b>LUTHERAN HOSP.</b>				
23a. BURIAL CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7-5-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. CAINARY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE md.</b>			
24. FUNERAL DIRECTOR NAME <b>Phillips</b> ADDRESS <b>1721-27 N. Monmouth St.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 9 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

00000



1945-1946  
1947-1948  
1949-1950

1951-1952  
1953-1954  
1955-1956

1957-1958  
1959-1960  
1961-1962

1963-1964  
1965-1966  
1967-1968

1969-1970  
1971-1972  
1973-1974

1975-1976  
1977-1978  
1979-1980

1981-1982  
1983-1984  
1985-1986



# STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME  
(TYPE OR PRINT) **Thomas Robert Carroll**

2a. DATE KNOWN OF DEATH ☒ MONTH **6** DAY **21** YEAR **79**

2b. HOUR **9:40**

3. SEX **Male**

4. RACE **White**

5. DATE OF BIRTH **Dec. 20, 1948**

6. AGE (IN YEARS) **30 YRS.**

7. DATE PRONOUNCED DEAD **6 21 19 79**

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) **Maryland**

7b. CITIZEN OF WHAT COUNTRY? **USA**

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH **Baltimore City,** MD.

10. CITY OR TOWN OF DEATH **Baltimore**

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) **Union Memorial Hospital**

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **Drug Counselor**

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE **Maryland**

13b. CITY OR TOWN **Baltimore**

13c. INSIDE CITY LIMITS? YES ☐ NO ☒

13d. STREET ADDRESS **849 Kellogg Road**

14. FATHER'S NAME FIRST MIDDLE LAST **Douglas L. Carroll Sr.**

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST **Dorothea V. Ailes**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) **Yes**

16b. SOCIAL SECURITY NO. **216-52-9250**

17. INFORMANT ADDRESS **Mr. Douglas L. Carroll 6109 Bellingham Ct.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Blunt injury to head**  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR **10:30** AM MONTH **6** DAY **17** YEAR **19 79**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) **Subject fell down steps**

21d. INJURY OCCURRED WHILE ☐ AT WORK ☒ NOT WHILE AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) **steps**

21f. LOCATION STREET CITY OR TOWN COUNTY STATE **2331 N. Calvert St. Baltimore Md.**

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

22b. TITLE (SPECIFY) **Assistant** MEDICAL EXAMINER

22c. DATE SIGNED **6/22/79**

22d. EXAMINER'S NAME (TYPE OR PRINT) **Virginia L. Dolan, M.D.** ADDRESS **111 Penn Street**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) **Burial**

23b. DATE **6/25/79**

23c. NAME OF CEMETERY OR CREMATORY **Dulaney Valley Cemetery**

23d. LOCATION CITY OR TOWN COUNTY STATE **Baltimore Maryland**

24. FUNERAL DIRECTOR NAME ADDRESS **Ruck Towson Funeral Home, Inc. 1050 York Road**

25a. DATE REC'D. BY REGISTRAR **JUN 26 1979**

25b. REGISTRAR'S SIGNATURE **Patricia K. B...**

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

10001



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 14002		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Vesta Elmira		CARSON		6		30-79		8:25 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR		90 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New Jersey		U.S.A.				Baltimore City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Lutheran Hospital		Housewife		Homemaking			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD		Baltimore		Columbia		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3330 Wilkins Ave	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
William P Harman		Victoria A Peterson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		215-12-0929		Miss Gloria Carson 6642 Walther Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Renal failure									
5990 } DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: } (b) nephrocalcinosis									
DUE TO, OR AS A CONSEQUENCE OF (c) UTI & CHF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED					
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		P.M.		19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
R. D. Faluja		M.D.				6/30/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
R. D. Faluja		1600 Mt. Royal Avenue							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. STATE	
Burial		7/5/79		Loudon Park Cem.		Baltimore		Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
NAME		ADDRESS		JUL 6 1979		Barry McCreedy			
Lassahn Funeral Home		7401 Belair Road							

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DHMH-16 20M  
(VRA 15, 4) 7/78

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 14003

1 DECEASED NAME (TYPE OR PRINT) <b>JOSEPH Fuller Carter, Jr</b>			2a DATE OF DEATH MONTH DAY YEAR <b>June 23, 79</b>			2b HOUR <b>1215p.m</b>			
3 SEX <b>Male</b>		4 RACE <b>Bl</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>May 16 34</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Balti City</b> MD			
10 CITY OR TOWN OF DEATH <b>Balti</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE, GIVE STREET ADDRESS) <b>USPHS Balti Md</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MECHANIC</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Balti City</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md</b> 13b. COUNTY <b>Balt</b> 13c. CITY OR TOWN <b>Balti</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>609 Richmond Ave</b>				
14 FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH F. Carter</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Flora Wilson</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (TYPE AND BRANCH KNOWN) <b>YES</b> (IF YES, GIVE WAR OR DATES) <b>VIETNAM</b>			16b SOCIAL SECURITY NO. <b>213 264 4536</b>		17 INFORMANT ADDRESS <b>PATIENT - WIFE above</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY Arrest</b> (b) <b>Cerebral Metastasis</b> (c) <b>Squamous Cell Carcinoma of Lung</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1629</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Superior Vena Cava Syndrome</b>									
19a DATE OF OPERATION <b>—</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>Feb 19 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Feb 19 79</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>June 19 79</b> to <b>June 19 79</b> , that (I) (we) lost saw the deceased alive on <b>June 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did) not view the body after death.									
22b. SIGNATURE <b>D Brooks MD</b> DEGREE <b>MD</b>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>24 June 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DENNIS Brooks MD</b>			22e. ADDRESS <b>USPHS Balti Md</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>June 28, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto National Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MARYLAND</b>		
24 FUNERAL DIRECTOR NAME <b>Frederic E. Nutter</b> ADDRESS <b>3035 W. North Ave</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McCreedy</b>				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 14004

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MATTIEL D. CARTER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6. 17. 79</b>			2b. HOUR MIN. <b>6.25</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5-15-93</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALT. CITY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LUTHERAN HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BEAUTICIAN</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>md</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1501 N. DuKeland St.</b> 21216	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALEXANDER DENNIS</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HELEN A. CHEW</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT ADDRESS <b>LUCILLE VENTURE / 3505 W. FOREST PARK AVE.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESP. ARREST.</b> 4092 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD AND PVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>GANGRENE OF FEET.</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>GANGRENE OF FEET.</b>									
19a. DATE OF OPERATION <b>6.4.79</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GANGRENE (R) foot</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4.17.79</b> 19____, to <b>6.17.79</b> 19____, that (I) (we) last saw the deceased alive on <b>6.17.79</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>DR BHAT</b> MD						22c. DATE SIGNED <b>6.17.79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR BHAT</b>						22e. ADDRESS <b>LUTHERAN HOSP.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>06/20/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Matthews U.M. Chur.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Shadyside Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Marshall W. Jones, Jr.</b>						ADDRESS <b>F.H./4101 Edmondson Ave.</b>		DATE REC'D. BY REGISTRAR <b>JUN 20 1979</b>	
						25b. REGISTRAR'S SIGNATURE <b>P. J. H. H. H.</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Willie T. CASON			2a. DATE OF DEATH MONTH DAY YEAR June 28, 1979			2b. HOUR 5:07 A.M.	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 7 25, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1800 N. Smallwood Street	
14. FATHER'S NAME FIRST MIDDLE LAST George Cason						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-10-8714		17. INFORMANT ADDRESS A Queen V. Cason 1800 N. Smallwood St.							
--	--	--	--	---	--	--	--	--	--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years	
--	--	--	--	--	--	--	--	--	--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic Renal Failure, Osteomyelitis Right Foot</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					

22a. I certify that (I) <del>did not</del> attended the deceased from <u>May 14</u> , 19 <u>79</u> , to <u>June 28</u> , 19 <u>79</u> , that (I) <del>did not</del> saw the deceased alive on <u>June 28</u> , 19 <u>79</u> , and that in my <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did not</del> view the body after death.											
22b. SIGNATURE <i>Cedric Bryan</i>						DEGREE MD			22c. DATE SIGNED 6/28/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Cedric Bryan, M.D.						22e. ADDRESS c/o Maryland General Hospital					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/2/79		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F.H./1101 E. North Ave.						25a. DATE REC'D. BY REGISTRAR JUL 2 1979		25b. REGISTRAR'S SIGNATURE <i>Jeffrey M. Brady</i>			

20041



added info g535 9/20/79 g3

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 14006

REG. NO.:

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
FIRST MIDDLE LAST COLES BB CATHERINE			MONTH DAY YEAR 6/21/79			9.43 AM			
3 SEX M		4 RACE Black		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
				MONTH DAY YEAR 6 18 79		YRS MONTHS DAYS 3 1 3		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE		7b. CITIZEN OF WHAT COUNTRY? BALTIMORE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BCH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY BALTIMORE		13c. CITY OR TOWN Baltimore city		13d. STREET ADDRESS 1542 Wolfe St			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE.</u> <u>7798</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Extreme prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Renal failure.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pneumothorax; Hyperbilirubinemia.</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/18/79</u> to <u>6/21/79</u> , that (I) (we) last saw the deceased alive on <u>6/21/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>SAROT MEHTA</u> DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SAROT MEHTA</u>						22e. ADDRESS <u>BCH</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR <u>JUL 16 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

14007

1. DECEASED-NAME (Type or print) <b>Lottie V. Chambers</b>			2a. DATE OF DEATH Month <b>6</b> Day <b>8</b> Year <b>79</b>			2b. HOUR <b>5:45 PM</b>				
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH <b>6-10-1895</b>		6. AGE (In years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto</b>				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DUKE Land Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md.</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>904 Stoddard Ct.</b>	
14. FATHER'S NAME First <b>James</b> Middle <b>Green</b> Last <b>Prater</b>			15. MOTHER'S MAIDEN NAME First <b>Sarah</b> Middle <b>Prater</b> Last <b>Prater</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>213-267796</b>		17. INFORMANT Address <b>Mrs. Sarah Thomas 1618 E. Lanvale St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Colon, Metastatic</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>3 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 7</b> , 19 <b>79</b> , to <b>JUNE 5</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>MAY 7</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Nathanial George Hager III</b>						22c. DATE SIGNED <b>JUNE 8, 1979</b>				
22d. PHYSICIAN'S NAME (Type) <b>NATHANIEL GEORGE HAGER III</b>						22e. ADDRESS <b>415 DRURY LANE BALTIMORE MD. 21229</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>6-13-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTO. md.</b>			
24. FUNERAL DIRECTOR <b>Samuel T. Redd</b>				ADDRESS <b>5209 YORK Rd. BALTO. md.</b>		25a. REC'D BY REGISTRAR <b>JUN 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barbara M. ...</b>		

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 14008

1. DECEASED NAME (TYPE OR PRINT) <b>Russell John Channer, Sr.</b>			2a. DATE OF DEATH MONTH <b>6</b> DAY <b>24</b> YEAR <b>79</b>			2b. HOUR <b>4:30 P.M.</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>June</b> DAY <b>21</b> YEAR <b>1979</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77 yrs.</b>		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>England</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Pikesville</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>918 Adana Rd.</b>					
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Joseph</b> LAST <b>Channer</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Amy</b> MIDDLE <b>Matilda</b> LAST <b>Rawlings</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO <b>073-16-7429</b>		17. INFORMANT ADDRESS <b>5550 Eliot's Oak Road</b> <b>Russell Channer, Jr. Columbia, Md. 21044</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic obstructive lung disease</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6-20-79</b> to <b>6-24-79</b> , that (I) (we) last saw the deceased alive on <b>6-24-79 194-298 M</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>P. VANKINENI</b>						DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>6/24/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. VANKINENI</b>						22e. ADDRESS <b>900 CATON AVE BALTIMORE MD-21229.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>June 27, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>All Saints Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Reisterstown Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>H. E. Ebbott</b> ADDRESS <b>Owings Mills, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 28 1979</b>			25b. REGISTRAR'S SIGNATURE <b>H. E. Ebbott</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

80041



BALTIMORE CITY

ST. LOUIS LEGITIM

BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 4 0 0 9	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Dorothy L. Chester</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6/25/79</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 15 43</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>35</b> YRS	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospitals</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>	
13c. CITY OR TOWN <b>Essex</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <b>385 Langley Road</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles G. Bryan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha H. Thamer</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>385 Langley Rd. Earl W. Chester - Balto, MD 21221</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b> <b>1749</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Breast Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6/25</b> 19 <b>79</b> , to <b>6/25</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/25</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>David Mishkin MD</b>				22c. DATE SIGNED <b>6/25/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David Mishkin MD</b>				22e. ADDRESS <b>Balto City Hosps</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/29/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Baltimore, MD</b>					
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 28 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>Robert...</b>	

MEDICAL CERTIFICATION

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3-30-50

1. The first part of the report is a general description of the project. It includes a statement of the purpose of the project, a description of the methods used, and a summary of the results. The second part of the report is a detailed description of the results. It includes a discussion of the data, a comparison of the results with previous work, and a conclusion. The third part of the report is a bibliography. It lists the references used in the report.

2. The second part of the report is a detailed description of the results. It includes a discussion of the data, a comparison of the results with previous work, and a conclusion. The third part of the report is a bibliography. It lists the references used in the report.

3. The third part of the report is a bibliography. It lists the references used in the report.

4. The fourth part of the report is a bibliography. It lists the references used in the report.

5. The fifth part of the report is a bibliography. It lists the references used in the report.

6. The sixth part of the report is a bibliography. It lists the references used in the report.

7. The seventh part of the report is a bibliography. It lists the references used in the report.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.		7 14010					
1. DECEASED NAME (TYPE OR PRINT) CHILDS, PERCY N.M.I.				2a. DATE OF DEATH MONTH 6 DAY 9 YEAR 79		2b. HOUR 12:10P M			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 10 DAY 10 YEAR 10		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, 3900 LOCH RAVEN BLVD., 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY Balto.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13. STREET ADDRESS 1672 DORLEY AVE. BALTO, 21213			
14. FATHER'S NAME FIRST MIDDLE LAST Abraham Child				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Wesley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 213 10 2439		17. INFORMANT ADDRESS Marie Childs 1672 Darley Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 185- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Prostatic CA (Carcinoma)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>METASTATIC</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1672 DORLEY AVE., BALTO. MD. 21213					
22a. I certify that (this hospital) attended the deceased from 5-8 19 79, to 6-9 19 79, that (if (we) lost saw the deceased alive on 6-9-19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (all) (we) (and) did not view the body after death.									
22b. SIGNATURE DEGREE JAMES E. HARRELL JR				22c. DATE SIGNED 6/9/79				22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES E. HARRELL JR	
22e. ADDRESS L R V A H				22f. DATE REC'D. BY REGISTRAR JUN 12 1979				22g. REGISTRAR'S SIGNATURE R. H. H. H.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/12/79		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25. DATE REC'D. BY REGISTRAR JUN 12 1979			

01041

DATE: 10-2-68

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charlotte B. Christhlf					2a DATE OF DEATH MONTH DAY YEAR 6 19 1979			2b HOUR M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 12 12 1915		6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 373 Homeland Southway				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Md.		13b COUNTY		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 373 Homeland Southway	
14 FATHER'S NAME FIRST MIDDLE LAST Charles J. Bolgiano					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Cullen				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 40 5635		17 INFORMANT ADDRESS John F. Christhlf Same					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of Vomitus</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>June 1</u> 19 <u>46</u> , to <u>April 19</u> 19 <u>79</u> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE W. Grafton Hersperger					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED June 19, 1979	
22d PHYSICIAN'S NAME (TYPE OR PRINT) W. Grafton Hersperger M.D.					22e ADDRESS Medical Arts Bldg				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 6/21/1979		23c NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Pikesville MD			
24 FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home 6500 York Rd.					25a DATE REC'D. BY REGISTRAR JUN 20 1979		25b REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 14013

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ARTHUR FABIAN CLARK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>06 13 79</b>		2b. HOUR <b>11 01 PM</b>
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 27 10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3019 GUILFORD AVENUE, 21218</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SOLD SEAFOOD</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FOOD</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FENTON CLARK</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>AGNES TUTTLE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-03-8784</b>		17. INFORMANT ADDRESS <b>MARY L. CLARK, 3019 GUILFORD AVENUE, 21218</b>	
18. CAUSE OF DEATH (Enter only one cause pending for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> <b>185-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cancer cachexia</b> (c) <b>metastatic prostate cancer</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>anemia and uremia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>May 6</b> , 19 <b>73</b> , to <b>June 13</b> , 19 <b>79</b> , that (I) (we) last saw, the deceased alive on <b>June 13</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) saw the body after death.					
22b. SIGNATURE <b>Horst Schirmer MD</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6/15/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HORST K. SCHIRMER, M.D.</b>				22e. ADDRESS <b>3 E. 33rd STREET, BALTIMORE, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>06-16-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>Harry K. ...</b>	

MEDICAL CERTIFICATION

29

BP

1041 87

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4, 5, AND 6 TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR OFFICE AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH KNOWN OF ESTIMATED		MONTH		DAY		YEAR		2b. HOUR			
Edward						Clark		6		21		19		79		M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Male	Black	1 3 29		50 YRS.						6		21		19		79		2:25 P M	
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Md.		USA		Baltimore City, MD															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Church Home and Hospital																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS											
Md.				Balto.				4124 Mountwood Rd.											
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
George				Clark				Ethel				Griffin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
No								Evelyn Franklin 4145 Fairview Ave											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART I DEATH WAS CAUSED BY: <u>Stab wound of abdomen with massive internal</u>																			
IMMEDIATE CAUSE (a) <u>966-</u> <u>hemorrhage</u>																			
DUE TO, OR AS A CONSEQUENCE OF																			
(b) <u>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</u>																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <u>1:00</u> MONTH <u>6</u> DAY <u>21</u> YEAR <u>19 79</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
								Subject stabbed by unknown assailant											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
				sidewalk				1101 Orleans St., Baltimore				Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				TITLE (SPECIFY)								DATE SIGNED							
<u>Virginia L. Dolan</u>				Assistant								6/22/79							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Virginia L. Dolan, M.D.				111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				6/26/79				King Mem. Pk.				Baltimore Co., Md.							
24. FUNERAL DIRECTOR NAME ADDRESS								25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Wm C March F/H 1101 E. North Ave.								JUN 26 1979				<u>History McCreedy</u>							

79 1041 8

10/10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 9 1 4 0 1 5 REG. NO. 445								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>REX JAMES NELSON CLARK</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6/13/79</b>					2b. HOUR <b>10:45 P</b>
3 SEX <b>MALE</b>		4 RACE <b>CAUCASIAN</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>10/18/1919</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>59</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>AA Co., Md.</b>		8b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>				
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Real Estate Agent</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Md.</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Odenton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>456 Oakton Avenue</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Owen Richard Clark</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel L. Jordan</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW 2</b>		17. INFORMANT ADDRESS <b>Mrs. Dorothy Clark, wife, same as 13</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>LUNG CANCER</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 WEEKS</b> <b>8-9 MONTHS</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>METASTATIC CANCER; ARTERIOSCLEROSIS</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED NATURE OF INJURY IN ITEM 18, PART I OR PART 2						
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Stanley G. Modersohn M.D.</b>		22c. DATE SIGNED <b>6/13/79</b>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stanley G. Modersohn M.D.</b>		22f. ADDRESS <b>SINAI HOSPITAL</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>18 June 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, AA, Md.</b>				
24. FUNERAL DIRECTOR NAME <b>James S. Kirkley, Glen Burnie, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barney Keeney</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Luther Tiffery Clark</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 1, 1979</b>			2b. HOUR <b>405 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-19-25</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DIS/Chauffeur</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ira B. Clark</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Shoemaker</b>			13e. STREET ADDRESS <b>2933 Mallview Road 21230</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>218-18-7991</b>		17. INFORMANT ADDRESS <b>Hospital admission sheet</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>496-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cor Pulmonale</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Chronic Obstructive Pulmonary Disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>4/9</b> , 19 <b>79</b> , to <b>6/1</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/1</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Joseph H. Miller, MD</b>		DEGREE		22c. DATE SIGNED <b>6/1/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 5, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, A.A.Co. Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>John H. Kelly</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JIMMIE LEROY CLIFTON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 21 79</b>			2b. HOUR <b>2:10a</b> M			
3 SEX <b>MALE</b>		4 RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 21 16</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINTA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VETERANS ADMINISTRATION MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3012 CHELSEA Terrace</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN LEE</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CHRISTINA CLIFTON</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>239223985</b>		17. INFORMANT <b>LUCILLE CLIFTON</b>		ADDRESS <b>3012 CHELSEA TERRACE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>1509</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Disseminated Eryth. Ca</b> (c) <b>Disseminated Eryth. Ca</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JUNE 8 19 79</b> to <b>JUNE 21 19 79</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased <input checked="" type="checkbox"/> above <input checked="" type="checkbox"/> view the body after death.									
22b. SIGNATURE <b>R. Smith MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>6-21-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. Smith MD</b>				22e. ADDRESS <b>3900 LOCH RAVEN BLVD 21218</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL</b>		23b. DATE <b>6-24-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. DELIGHT CHURCH CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>FRANKLIN COUNTY NORTH CAROLINA</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>ARLINGTON S. PHILLIPS FUN. 1721-27 N. MONROE</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 25 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 14018

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		MONTH DAY YEAR	
Ottis Fauntleroy Clingerman		June 6, 1979		11:09 A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	Caucasian	Apr. 2, 1902	77	MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Md.	USA		Balto. City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Balto. City	US Public Health Service Hospital	Retired			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md.		Balto.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3323 Chestnut Ave.	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
Harvey Clingerman	Clara Fletcher	NO			
16b. SOCIAL SECURITY NO		17. INFORMANT			
216-01-2948		Webster Ross Clingerman 2 Hydrangea Rd. Levittown, Penna			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:		Terminal			
IMMEDIATE CAUSE (a) 4148		DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) Congestive heart failure			
		DUE TO, OR AS A CONSEQUENCE OF			
		(c) Arteriosclerotic cardiovascular disease			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		Years			
Cerebrovascular accident, myocardial infarction-multiple					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from Jan. 16, 1979, to June 6, 1979, that (I) (we) lost saw the deceased alive on June 6, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death)					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Jose Alvarez-Bernal M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		6/7/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Jose Alvarez-Bernal M.D.		3100 Wyman Parkway Balto., Md. 21211			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	June 9, 1979	Druid Ridge Cemetery	Baltimore, Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REG'D. BY REGISTRAR	
A. Alan Seitz Funeral Home		3818 Roland Ave.		JUN 13 1979	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.		79 14019					
1. DECEASED NAME (TYPE OR PRINT) <b>JAMES CLOUD</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6 5 79</b>		2b. HOUR <b>7:45 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 22 34</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>44 45</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dep't. Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Federal Reserve Bank</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>15 Treeway Court Apt. 1B</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William A. Cloud</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Grace W. Walter</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-30-6981</b>		17. INFORMANT ADDRESS <b>Mrs. Grace W. Cloud 15 Treeway Court Apt. 1B</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septic peritonitis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Adenocarcinoma of stomach</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1519</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>June 3, 1979</b> , to <b>June 5, 1979</b> , that (I) (we) lost saw the deceased alive on <b>June 5, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>N. Zagloma M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>6/5/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>N. Zagloma</b>				22e. ADDRESS <b>The Good Samaritan Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>6-8-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b>				ADDRESS <b>5305 Harford Rd. Balto; Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 6 1979</b>		REGISTRAR'S SIGNATURE <b>Henry H. Brady</b>	



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FOR THE DIRECTOR, FBI, WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										9 1 4 0 2 0			
1- FOR STATE REGISTRAR		CERTIFICATE OF DEATH								REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
CHESTER			LOUIS			COPIELL			June 10 '79 10:25 p.m.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.		
MALE		WHITE		1 7 07		72 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND			U.S.A.						BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF MOLIN SUCH AS NURSING HOME, STATE, ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE			ST AGNES HOSPITAL						RETIRED-BARTENDER		bar		
13a. STATE			13b. CITY OR TOWN		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Maryland			Baltimore		Halethorpe		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4320 Ridge Avenue				
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Louis E. Copiell						Grace L. Phillips							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS				
yes			216-09-6207			Ethel H. Copiell			4320 Ridge Avenue 21227				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 5324 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Duodenal ulceration, with GI</u> (c) <u>Bleeding (Bilrotti I anastomosis)</u> 21 days PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Myocardial infarction - Left ventricle</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
5/17/1979			Bleeding duodenal ulcer			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
			P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from 5/16, 19 79, to 6/10, 19 79, that (we) lost the deceased alive on 6/10, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.										22b. SIGNATURE		22c. DATE SIGNED	
Joan E. Whitehouse, M.D.										6/11/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS							
JOAN E. WHITEHOUSE, M.D.						900 S Caton Ave., Balto. Md. 21229							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
burial			6/14/79		Meadowridge Cemetery		Dorsey Howard Maryland						
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Ambrose Funeral Home 1328 Sulphur Spring Rd.						JUN 13 1979		[Signature]					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

RBG. NO. 6-1-1979

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Fannie Cohen</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>4-1-1898</b>		2b. HOUR <b>8:45</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4-1-1898</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HEBREW HOME</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>City - BALTIMORE</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		13a. STREET ADDRESS <b>2500 W. BELVEDERE AVE. #21215</b>	
13b. COUNTY <b>md</b>		13c. CITY OR TOWN <b>Balti</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>BERNARD</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SYLVIA BROWNSTEIN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	
16b. 215-01-56440 <del>XXXXXXXXXX</del>		17. INFORMANT MR. DANIEL KATZ 1308 PINE RIDGE LA. #21208			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Arteriosclerotic Heart disease</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Yrs.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Congestive Heart failure, post permanent pace-maker, perkinson's disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>5/30/1979</b> to <b>6/1/1979</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8:30pm 6/1/1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>K HIN M. TUN</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/1/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K HIN M. TUN</b>		22e. ADDRESS <b>Levinale Geriatric centre and Hosp.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JUNE 5, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OUR KNESSETH ISRAEL ANSHE SFARD</b>	
23d. LOCATION <b>ROSEDALE BALTO. MD</b>					
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Petry Helms</b>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <b>ROSE KAY COLLISON</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>06 12 79</b>		2b. HOUR <b>12:50 PM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 10, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Clin Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>105 Franklin Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Apolos W. Kay</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Blanche H. Pitts</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>217-16-5374</b>		17. INFORMANT ADDRESS <b>Mr. Fred B. Collison 452 Gayle Drive</b>				17b. ADDRESS <b>Linthicum, Md. 21090</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute inferior M.I.</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Diabetes Mellitus &amp; Cerebrovascular accident</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/29/79</b> 19 <b>79</b> , to <b>6/12</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/12</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>D. S. Kalaria</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. S. KALARIA</b>				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/16/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Anne Arundel Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Mc Cully Funeral Home of Brooklyn</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 18 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>MAJOR CONIGLAND</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>June 27, 1979</b>		2b. HOUR <b>9:10 P.</b>					
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2/ 2/ -94-93</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pleasant Manor N. H.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>KITT CONIGLAND</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LEAH</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-20-9474</b>		17. INFORMANT ADDRESS <b>Pleasant Manor Nursing Center 4615 Park Heights Ave., 21215</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Poorly Differentiated Ca of Prostate Gld.</b> <b>185-</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>4-4</b> , 19 <b>79</b> , to <b>6-27</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6-27</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Jaime Punzalan</b>				22c. DATE SIGNED <b>6-28-79</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jaime M. Punzalan, M. D.</b>				22e. ADDRESS <b>5214 Harford Road, 21206</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/2/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>					
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Co., Md.</b>									
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H 1101 E. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 2 1979</b>					
				25b. REGISTRAR'S SIGNATURE <b>Robert McBrady</b>					

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NOT A PART OF THE RECORD  
EX-100-100000-10-10

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14024

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Frank W. Conner</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>06 19 79</b>		2b. HOUR <b>10<sup>05</sup> M</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>Aug. 11, 1945</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>33 years</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bar Tender</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Frank Conner</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Casteel</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>215-42-5083</b>		17 INFORMANT ADDRESS <b>Mrs. Reba F. Conner, 1317 Hollins Street Balto., Md. 21223</b>
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 1j, 1k, 1l, 1m, 1n, 1o, 1p, 1q, 1r, 1s, 1t, 1u, 1v, 1w, 1x, 1y, 1z) PART I. DEATH WAS CAUSED BY: <b>5715 Hepatic failure - (2 weeks)</b> IMMEDIATE CAUSE (a) <b>Cirrhosis of the liver</b> DUE TO, OR AS A CONSEQUENCE OF: b) <b>several years</b> c) <b>months</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: DUE TO, OR AS A CONSEQUENCE OF: PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (his hospital) attended the deceased from <b>6-19-79</b> to <b>6-19-79</b> , that (1) (we) lost saw the deceased alive on <b>6-19-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Octavio A. Ruiz MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/19/79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Octavio A. Ruiz MD</b>		22e. ADDRESS <b>Bon Secours Hosp Fayette and Wilkes St Balto Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>6/23/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Howard County, Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>		ADDRESS <b>4107 Wilkens Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 21 1979</b>
				25b. REGISTRAR'S SIGNATURE <b>Rita Kelly</b>

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE REGISTRAR. GIVE PAGES 4 AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14025	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>John (Johnny) T. Cooper</b>						2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 25 19 79</b>		2d. HOUR <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 27 27</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.		IF UNDER 1 YR. MONTHS DAYS <b>51</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 25 19 79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1385 N. Gilmore Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1385 N. Gilmore St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Cooper</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eleanor</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WWII</b>				16b. SOCIAL SECURITY NO. <b>224-36-8623</b>		17. INFORMANT ADDRESS <b>Mary A. Cooper 802 N. Dukeland St</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Ann M. Dixon</i>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>6/25/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6/30/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>						ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 27 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Anthony McCreedy</i>	

## SOURCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
REG. NO. 79 14026									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nellie M. Cotton						2a. DATE OF DEATH MONTH DAY YEAR 06-09-79		2b. HOUR 6:25 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-23-11		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH Charles Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN 13e. STREET ADDRESS Maryland City Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 2020 Maryland Ave.									
14. FATHER'S NAME FIRST MIDDLE LAST Walter D. Lanning					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Miss R. Lethco				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 227-382346		17. INFORMANT ADDRESS /Rev. Currie F. Parker, Hayesville, N. C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL CANCER OF THE</u> <u>PANCREAS WITH METASTASIS TO</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>THE LIVER &amp; Brain</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1579</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>SEVERE ASCITES</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/30</u> 19 <u>78</u> to <u>6/9</u> 19 <u>78</u> , that (I) (we) last saw the deceased alive on <u>6/9</u> 19 <u>78</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE K. D. HARMASENA				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 6/11/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. D. HARMASENA				22e. ADDRESS 2724 N. Charles St. Baltimore Md 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-12-79		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge, Howard, Maryland			
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR JUN 12 1979		25b. REGISTRAR'S SIGNATURE L. J. McCreedy			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO. 14027							
1. DECEASED NAME (TYPE OR PRINT) <b>LESLIE E COURTNEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>06/10/79</b>			2b. HOUR A <b>9:50</b> M				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 24, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN) <b>BALTIMORE, Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>M BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cannon Shoe Co.</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Cockeysville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Box 137, Poole Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Leslie Earl Courtney</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dean Adams</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW11</b>		17. INFORMANT ADDRESS <b>Mary M. Courtney, Same As #13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial Bleed</b> 2050 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <b>Thrombocytopenia</b> 17 days DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Myelogenous Leukemia</b> 17 days									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>POSSIBLE SEPSIS</b>										
19a. DATE OF OPERATION <b>—</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <b>05/23</b> , 19 <b>77</b> , to <b>06/10</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>06/10</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Gregory L. Walker MD</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>06/10/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GREGORY L. WALKER MD.</b>			22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6-13-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cockeysville, Balto. Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Md. wlv</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 4 0 2 8		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) CHARLES RUSSELL COX			2a. DATE OF DEATH MONTH DAY YEAR 6 21 79			2b. HOUR 9:35 PM			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR FEB 15 1940		6. AGE (IN YEARS LAST BIRTHDAY) 39		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MD HOSP			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY WORKER CONSTRUCTION		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY —		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 111 W. Centre St, Balt Md	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES W. COX			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GLADYS VICKERS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 217-34-8079		17. INFORMANT CHARLES WILLIAM COX		ADDRESS CHESTER MD 21519			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC ENCEPHALOPATHY</u> 5711 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>ALCOHOLIC HEPATITIS/CIRRHOSIS</u> (c) <u>ALCOHOL ABUSE</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ACUTE RENAL FAILURE</u>									
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-22</u> , 19 <u>79</u> , to <u>6-21</u> , 19 <u>79</u> , that (we) lost saw the deceased alive on <u>6-21</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.									
22b. SIGNATURE S. Valenti MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6/21/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN A. VALENTI MD				22e. ADDRESS 22 S. GREENE ST. BALTO, MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-25-79		23c. NAME OF CEMETERY OR CREMATORY KINGSLEY CHURCH CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE CHESTER MD			
24. FUNERAL DIRECTOR NAME HELFENBEIN-HUBBARD FUN. HOME				ADDRESS RT #1 BOX 61		25a. DATE REC'D. BY REGISTRAR JUN 27 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14029

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Mary A. Crawford</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6/8/79</b>		2b. HOUR <b>M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug 10, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78 yrs.</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore city</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>851 West 34th Street</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>	13b. COUNTY <b>--</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>851 West 34th Street 21211</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Harrison</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unk</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-05-0595</b>	17. INFORMANT ADDRESS <b>Mr. Harry Crawford, Sr 851 W. 34th Street</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of colon</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION <b>9/9</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>June 1, 19 68</b> to <b>June 8, 19 79</b> , that (I) (we) last saw the deceased alive on <b>Feb 8, 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>L. Wallenstein MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/8/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L. WALLENSTEIN</b>		22e. ADDRESS <b>711 W 40th St</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/11/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR NAME <b>A. Alan Seitz</b>		ADDRESS <b>Funeral Home 3818 Roland Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 13 1979</b>	25b. REGISTRAR'S SIGNATURE <b>History Maloney</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Items 3, 6, 15 8535 7/27/79 83

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 4 0 3 0

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ADELNE CRENshaw			2a. DATE OF DEATH MONTH DAY YEAR 6 20 79			2b. HOUR 3:05 PM	
3. SEX F	4. RACE N	5. DATE OF BIRTH MONTH DAY YEAR 7 6 05		6. AGE (IN YEARS LAST BIRTHDAY) 73 74 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 2a.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.		13b. COUNTY USA		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Isham		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriet Harris		13e. STREET ADDRESS 810 BROOKS LANE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-22-0516		17. INFORMANT ADDRESS 810 BROOKS LANE 21217			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 - Cardiorespiratory Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Cardiogenic Shock DUE TO, OR AS A CONSEQUENCE OF (c) Acute Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6-18 19 79, to 6-20 19 79, that (I) (we) last saw the deceased alive on 6-20 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. Reider		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 6-20-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ruben Reider M.D.		22e. ADDRESS BELVEDERE at GREENSPRING Ave Baltimore 21209					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/23/79		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 22 1979	
						25b. REGISTRAR'S SIGNATURE Ruthy McCreedy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 9 1 4 0 3 1				REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLORENCE M. CREW					2a. DATE OF DEATH MONTH DAY YEAR 6 9 79			2b. HOUR 12:20 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept 10, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Mordecia Peters					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unk					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-74-8259		17. INFORMANT ADDRESS Edgar Steigleman 5601 Gun Powder Rd						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <del>XXXXXX</del> DIFFUSE <del>XXX</del> CEREBRAL DAMAGE 5533 } DUE TO, OR AS A CONSEQUENCE OF HYPOXIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF CARDIAC ARREST (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS										
19a. DATE OF OPERATION 05 30 79			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED HIATUS HERNIA CHOLELITHIASIS, CHOLECYSTITIS				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from MAY 29, 19 79, to JUNE 9, 19 79, that (I) (we) lost saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE S.P. GIRDHAR						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6/9/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.P. GIRDHAR, M.D.						22e. ADDRESS CHURCH HOSPITAL, BALTIMORE, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/12/79		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Duda-Ruck Inc. Baltimore, Maryland						25a. DATE REC'D. BY REGISTRAR JUN 12 1979		25b. REGISTRAR'S SIGNATURE H. J. McCreedy		

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MEDICAL CERTIFICATION

FOR Items 18a. Film#G533										STATE OF MARYLAND										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										14032									
1- STATE 7-12-79 as REGISTRAR										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.																			
1. DECEASED NAME (TYPE OR PRINT) M ICHAE L CROMBIE										2a. DATE KNOWN OF DEATH ESTI- MATED 6 5 1979										2b. HOUR 7:50 a.m.																			
3. SEX male 4. RACE white 5. DATE OF BIRTH MONTH DAY YEAR 8 6 37 6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS. 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.										10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5311 Moravia Road 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY																													
13a. STATE Md. 13b. COUNTY - - 13c. CITY OR TOWN Balto. 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] 13e. STREET ADDRESS 5311 Moravia Rd.										14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 16b. SOCIAL SECURITY NO. 217-34-7693 17. INFORMANT ADDRESS										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty liver and Bronchopneumonia 5718 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES [X] NO [ ]																													
21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 21d. INJURY OCCURRED WHILE [ ] NOT WHILE [ ] AT WORK [ ] AT WORK [ ] 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE										22a. I certify that I took charge of the remains described above, held on Autopsy [X] Inspection [ ] Inquiry [ ] and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].																													
ACTUAL SIGNATURE Margaret A. K Orell M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 6/7/79										EXAMINER'S NAME (TYPE OR PRINT) Margaret A. K Orell, M.D. ADDRESS 111 Penn Street, Balto. MD 21201																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal 23b. DATE 6-21-79 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE										24. FUNERAL DIRECTOR NAME ADDRESS Anatomy Board Balto., Md. 25a. DATE REC'D. BY REGISTRAR JUN 27 1979 25b. REGISTRAR'S SIGNATURE																													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. If the death occurs in a hospital or at the residence of the decedent, the certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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NOT A MEDICAL EXAMINERS CASE PER DR. DIXON MEDICAL EXAMINER

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79 14033			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 7b. HOUR P			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WALTER C. CROUSE</b>				<b>JUNE 18, 1979 4:25 AM</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUGUST 22, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>55</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>INSTALLER, REPAIRMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TELE CO</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN <b>MARYLAND MONTGOMERY WHEATON</b>				13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>WALTER P. CROUSE</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>AIRY BELFIELD</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16b. SOCIAL SECURITY NO. <b>WW II 577-14-0387</b>		17. INFORMANT <b>MARY E. CROUSE</b>		ADDRESS <b>SAME AS 13 WIFE</b>	
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>4149 Heart failure following coronary bypass</b> IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary occlusive disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION <b>6/18/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Angina / Coronary artery disease</b>		19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Hartzell V. Schaff, MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HARTZELL V. SCHAFF, MD</b>				22e. ADDRESS <b>BALTIMORE, MARYLAND</b>			
23a. BURIAL, CREMATION, OR REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/22/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 25 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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WASHTON, D. C. U.S.A.	WHITE	MARKET ST. 1913	25	JULY 19, 1913	4-13
BALTIMORE	THE JOSEPH HENNING HOSPITAL	RESEARCH, RESEARCH, TELE CO			
MARYLAND HOSPITAL	WHEATON	1721 CONNOR STREET			
WALTER	P.	CRUISE	AIR	RECEIVED	
YES	NO	27-1-1913	MARY E. CRUISE	SAFE AS 12	WIFE

Handwritten notes: "Handwritten following", "Handwritten following", "Handwritten following"



Handwritten: "Address: [illegible]"

Handwritten: "11/18/43"

Handwritten: "Franklin D. Roosevelt", "Franklin D. Roosevelt"

5/22/40	DATE OF BIRTH	SILVER SPRING	NOT
FRANCIS J. COLLINS	500 W. 11th St., Silver Spring, Md. 20901	11/18/43	11/18/43

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 0 3 4

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
FIRST MIDDLE LAST Concetta Culotta		Female		White	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
MONTH DAY YEAR Sept. 5, 1897		81		Sicily	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
		Baltimore City		Baltimore	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
3201 Hamilton Ave.		Seamstress		Garment	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland				Baltimore	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
FIRST MIDDLE LAST Salvatore Manzella		FIRST MIDDLE LAST Josephine Dagostaro		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
213-10-8686		Samuel A/ Culotta		3210 Belair Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Goma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>with Metastasis</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 1 year					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/15</u> , 19 <u>69</u> , to <u>6/14</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/13</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Informant</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR	
I.W. Brown M.D.		8014 Old Harford Road Baltimore, Md.		JUN 15 1979	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		June 18, 1979		Holy Redeemer	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Leonard J. Ruck, Inc. Baltimore, Maryland				JUN 15 1979	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	
				History McCreedy	

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Conclusions

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14035

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
GERTRUDE WYNN CUMMINGS		6/22/79		4:30 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	BLACK	12 <sup>TH</sup> 2 <sup>DAY</sup> 1919	59	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Md.	U.S.A.		City		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	3906 Cranston Avenue		Nurse		Medicine
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3906 Cranston Avenue	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Charlie Harris		Carrie Harris			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
no		217 12 0706	Charles Cummings 3906 Cranston		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary failure</u> 1844 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Squamous cell Carcinoma of vulva with groin lymph node and lung metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Anemia and urinary infection</u> PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>79</u> , to <u>June</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/15</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Mr. S. D. Dolkar</u>		DEGREE M.D. F.A.C.S.		22c. DATE SIGNED 6/27/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. M. S. DIDOLKAR		22e. ADDRESS Univ. of Maryland Hosp. Baltimore Md 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		6/27/79		King Park	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
James A. Morton		JUN 28 1979		<u>Patricia Kennedy</u>	
1608		BP		STATE Md	



1 4 0 3 2

17- KNIFE WITH GUARD

BLACK 12 2 1212

MA. 1000 N. 7. A.

3000 Cranston Avenue

MA. 3000 Cranston Avenue

CRANSTON 3000

3000 Cranston Avenue



MA. 1000 N. 7. A. 3000 Cranston Avenue

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14036

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTIMATED		2d. HOUR	
Kenneth B Cunningham		X MONTH DAY YEAR 6 6 1979		M	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR	8. IF UNDER 24 HRS
M	W	AUG. 7 1909	22 YRS.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
MARYLAND	Baltimore	St. Agnes Hospital	STEAMFITTER		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MD	BALTO	LAYSPOWNE	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	4609 COLLEGE AVE	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			
GEORGE	BESSIE DUKES BAKER	YES			
16b. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
216 30 8678	MARGIE CUNNINGHAM	PART I DEATH WAS CAUSED BY:			
		IMMEDIATE CAUSE (a) Complications of multiple visceral skeletal injuries			
		DUE TO, OR AS A CONSEQUENCE OF			
		(b) DUE TO, OR AS A CONSEQUENCE OF			
		(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 (HEAD ONLY)			
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
	9:05 P.M. 5-16 19 79	fell or jumped from roof			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION			
	street	Leeds Ave & Maiden Choice Lane, Arbutus, Balto Co, MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE	TITLE (SPECIFY)	DATE SIGNED			
Virginia L. Dolan	Assistant	6/7/79			
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS	111 Penn Street, Balto. MD 2101			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY OR TOWN) COUNTY STATE		
BURIAL	6/11/79	LAKEVIEW	CARROLL COUNTY		
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
WEBER FUNERAL HOME	EDMONDSON AVE	JUN 12 1979	[Signature]		

2 2 0 1 1 1 1 1



VOIDED DEATH CERTIFICATE #79-14037

SEE JULY, 1979, City, Geneva Curry



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 4 0 3 8		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Pauline M. Curtis								6 15 79		12:00 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		Negroid		12-29-18		60 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.				CITY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTO.		PROVIDENT HOSP.									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.				BALTO.				4429 Pail Mail Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
William Smith		Jane Sowell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
NO		212-18-9215		JOSEPH CURTIS 1608 W. LANVALE ST.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). CARDIO RESPIRATORY FAILURE.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1509											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b). Po. Tracheobronch and C. Esophagelary											
DUE TO, OR AS A CONSEQUENCE OF (c). with Cerebral Hemiparesis.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
5/18/78		ca. Cerebral									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/21/78, 19 78, to 6/15/78, 19 78, that (I) (we) last saw the deceased alive on 6/15/78, 19 78, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
SWARAN K. ANAND.		MD.				6/15/78					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
SWARAN K. ANAND.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		6-20-79		PH. Auburn Cem.		BALTO. Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
VERNON Bailey		1348 CALHOUN ST.		JUN 19 1979		R. K. Bailey					

14033

Items 13a to 13e 5/22/79  
 FOR  
 1- STATE REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO. 14039

1 DECEASED NAME (TYPE OR PRINT)		FIRST Winfut		MIDDLE		LAST Cutler		2a DATE OF DEATH				MONTH 5		DAY 10		YEAR 79		2b HOUR 8:34P.M.													
3 SEX Male		4 RACE Black		5 DATE OF BIRTH		MONTH 2		DAY 18		YEAR 22		6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN													
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) va		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED		9 BALTIMORE CITY OR COUNTY OF DEATH City MD.																									
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) City 3 Hospital																													
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY																													
13a STATE Maryland		13b COUNTY		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 17 Goode Avenue																							
14 FATHER'S NAME				FIRST William				MIDDLE Cutler				LAST				15 MOTHER'S MAIDEN NAME				FIRST Eva				MIDDLE				LAST			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO 230.14-1013				17 INFORMANT James A. Alexandria												ADDRESS 115 Maple											
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordis Pulmonary Arrest</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u>																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																															
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																															
22b. SIGNATURE N.E. McCall M.D.												DEGREE M.D.				22c. DATE SIGNED 5/10/79				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N.E. McCall M.D.												22e. ADDRESS Bldg., 4440 Eastern Ave. Balt. Md. 21224																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/15/79				23c. NAME OF CEMETERY OR CREMATORY West View				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.																			
24. FUNERAL DIRECTOR NAME Catherine L. McCrumm												25a. DATE REC'D. BY REGISTRAR MAY 14 1979				25b. REGISTRAR'S SIGNATURE Rickey McCreedy															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1000 1000

1000 1000

1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 0 4 0

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
JOHN NMN CYMBOR		6 22 79		5:00 P <sup>M</sup>	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	Caucasian	MONTH 7 DAY 17 YEAR 07	71 YRS	MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U., S. A.		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	VAMC, Baltimore, Maryland 21218		Window Decorator		Department Stores
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland		Baltimore	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	5505 Belair Road
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Joseph Cymbor		Mary Tys Valiewicz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		214-03-2644		VAMC records, Baltimore, Maryland 21218	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest					Immediate
1579 DUE TO, OR AS A CONSEQUENCE OF (b) Obstructive Bowel					2 Weeks
DUE TO, OR AS A CONSEQUENCE OF (c) Cancer Pancreas					1 Year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)					
NONE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
2/14/79		Cancer Pancreas		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from January 2, 19 79, to June 22, 19 79, that (we) lost (saw the deceased alive on June 22, 19 79, and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) (saw the body after death).					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Charles Newton		M.D.		6/22/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Charles Newton		3900 Loch Raven Boulevard Baltimore, Maryland 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	23e. STATE
BURIAL		6-26-1979	Holy Rosary	BALTO	MD.
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J. Walter Conklin		JUN 28 1979		Anthony McCreedy	

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**NOT TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER MUST SIGN AND DATE THE BOTTOM OF THIS PAGE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
15M 7/76

1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH		79 14041 REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARCHIE L. DALE, JR.			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 6 6 79		2b. HOUR 12:31 P
3 SEX male	4 RACE black	5. DATE OF BIRTH MONTH DAY YEAR 2 18 68	6 AGE (IN YEARS) (LAST BIRTHDAY) 11 YRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 6 79	12:31 P
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital		12b KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Balto.	13c. STREET ADDRESS 3426 Childs Ct.	
14 FATHER'S NAME FIRST MIDDLE LAST Archie L. Dale, Sr.			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Gaskins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mattie Gaskins 3426 Childs Ct.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cranio-cerebral injuries</u> 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY M. MONTH DAY YEAR 12:20 6 6 79 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject struck by tractor trailer	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1400blk Chesapeake St. Baltimore, Maryland	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Margarita A. Korell		TITLE (SPECIFY) M.D. Assistant		DATE SIGNED 6/6/79	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/11/79	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN STATE Anne Arundel Co. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H 1101 E. North Ave.		25a. DATE RECEIVED BY REGISTRAR JUN 11 1979			

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

79 14042

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Ralph</i>	MIDDLE	LAST <i>Dallas</i>	2a. DATE OF DEATH		MONTH <i>6</i>	DAY <i>6</i>	YEAR <i>79</i>	2b. HOUR <i>6:54 PM</i>		
3 SEX <i>Male</i>		4 RACE <i>Black</i>		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS <i>61</i>		IF UNDER 24 HRS HOURS <i>61</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>? U.S.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.						
10 CITY OR TOWN OF DEATH <i>Baltimore City</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Univ. of Maryland Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Not known</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Not known</i>				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Balt. City</i>		13c. CITY OR TOWN <i>Baltimore</i>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2914 Forest Glen Road				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME							
FIRST <i>Jerry</i>		MIDDLE <i>Don't know</i>		LAST <i>Dallas</i>		FIRST <i>Mazernie</i>		MIDDLE <i>2</i>		LAST <i>Coleman</i> <i>Mazernie</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>unknown</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>264-10-0155</i>		17 INFORMANT ADDRESS <i>wife above address</i>								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>stage D Carcinoma of the Prostate</i> <i>185-</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3-4 years</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>None</i>												
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>5/28</i> , 19 <i>79</i> , to <i>6/6</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>6/5</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Gary F Harne</i>				DEGREE <i>MD</i>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>6/6/79</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GARY F HARNE MD</i>				22e. ADDRESS <i>5454 HARRIS FARM Road, Columbia, Md. 21044</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6/10/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Church Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Palatka Florida</i>						
24. FUNERAL DIRECTOR NAME <i>WM. C. MARCH F/H</i>				ADDRESS <i>1101 E. North Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 8 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Lutty K. Brady</i>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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THE OFFICE OF THE  
ATTORNEY GENERAL  
STATE OF NEW YORK



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## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14043

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>STEPHEN DAN YOV</b>			2a. DATE OF DEATH MONTH <b>06</b> DAY <b>15</b> YEAR <b>79</b>			2b. HOUR <b>6:35 P</b> M													
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH <b>07</b> DAY <b>26</b> YEAR <b>11</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b>		IF UNDER 24 HRS HOURS <b>00</b> MIN. <b>00</b>									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Chicago, Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.													
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Balto. General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Md. Drydock</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Shipfitter</b>											
13a. STATE <b>MD</b>			13b. COUNTY		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3716 5th ST.</b>										
14. FATHER'S NAME FIRST <b>Andrew</b> MIDDLE LAST <b>DANYOU</b>				15. MOTHER'S MAIDEN NAME FIRST <b>ANNA</b> MIDDLE LAST <b>KOCH</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>214 10 9714</b>				17. INFORMANT ADDRESS <b>Glen Burnie, Md.</b> <b>Anna Smith 7613 Marcy Dr. 21061</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORRESPIRATORY ARREST</b> 5728 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Liver FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from <b>06/29</b> , 19 <b>79</b> , to <b>06/15</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>06/15</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <b>M. Fleischman</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>06/15/79</b>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. Fleischman</b>						22e. ADDRESS <b>South Balto. General Hosp.</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/18/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Brooklyn</b> COUNTY <b>A.A.</b> STATE <b>Md.</b>		24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b> ADDRESS <b>4001 Ritchie Hgwy</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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KOOLIT

George A. Jones 4001 Alameda Ave. S.E. Seattle 2, Wash. D.C. 98104



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 14044

1- FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		HOUR	
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		6/14/79		3:25 PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
MALE		WHITE		FEB/22/1899		80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		USA				BALTIMORE CITY MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		SINAI HOSPITAL		EXECUTIVE		TRANSFER CO.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		APT. 1407			
ISAAC W. DAVIDSON		EMMA G. GOLDBERG		8500 GLENN MICHAEL LA., RANDALLSTOWN, MD 21133			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		17b. ADDRESS	
NO		212-09-1135		MISS IDA MILLER		APT. 105	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
2500		CARDIO PULMONARY ARREST		SECONDS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF		MONTHS			
		(b) ACUTE & CHRONIC RENAL FAILURE					
		DUE TO, OR AS A CONSEQUENCE OF		YEARS			
		(c) DIABETES MELLITUS, ATHEROSCLEROSIS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		PELVIC FRACTURE, PNEUMONIA, PROBABLE ASPIRATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY		20c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR					
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. LOCATION		CITY OR TOWN COUNTY STATE	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET			
22a. I certify that (1) (this hospital) attended the deceased from 5/28/79 to 6/14/79, that (1) (we) last saw the deceased alive on 6/14/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED			
STANLEY G. MIDDLETON		6/14/79					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		JUNE 17, 1979		CHIZUK AMUNO		BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME SOL LEVINE & BROS., INC.		JUN 19 1979		Anthony K. Brady			
6010 REISTERSTOWN RD., BALTO., MD 21215							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

W. A. D. 12-13-14

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 14045									
1. DECEASED NAME (TYPE OR PRINT) <b>BERNICE E. DAVIS</b>					2a. DATE OF DEATH MONTH DAY YEAR 6 28 74					2b. HOUR 6:05 PM	
3. SEX Female		4. RACE <b>Cauc- white</b>		5. DATE OF BIRTH MONTH DAY YEAR 5 2 15		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Receptionist</b>			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13b. STREET ADDRESS <b>3322 Shelburne Road</b>			
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Vincent White</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Exner</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>357-05-7090</b>		17. INFORMANT ADDRESS <b>Mrs. Eleabore Hartlove 3322 Shelburne Rd.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPulmonary Arrest</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
3489 DUE TO, OR AS A CONSEQUENCE OF (b) <b>TUMOR (BRIN Versus Infant</b>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/28</b> , 19 <b>74</b> , to <b>6/28</b> , 19 <b>74</b> , that (I) (we) last saw the deceased alive on <b>6/28</b> , 19 <b>74</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>J M Starr MD</b> DEGREE						22c. DATE SIGNED <b>6/28/74</b>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jay M Starr</b>		
22e. ADDRESS <b>Sinai Hospital</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7-2-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. 5305 Harford Rd. Balto; Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1979</b>			25b. REGISTRAR'S SIGNATURE <b>History McBrady</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Dorothy Carter Davis</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6 - 29 - 79</i>			2b. HOUR <i>9 P.M.</i>			
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>OCT 3 1925</i>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>55</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Balti City</i> MD.			
10. CITY OR TOWN OF DEATH <i>BALTO</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>BALTO City Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housekeeper</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE <i>MD</i>		13b. COUNTY		13c. CITY OR TOWN <i>BALTO</i>		13e. STREET ADDRESS <i>810 N Kenwood Ave</i>			
14 FATHER'S NAME FIRST MIDDLE LAST <i>Stanley A Carter</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mellie Valentine</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>229-14-8761</i>		17 INFORMANT ADDRESS <i>Ernest E Davis Same</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>heart shock</i> <i>486-</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>10 days</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 hrs</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Cirrhosis</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>June 19</i> 19 <i>79</i> , to <i>June 29</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>June 29</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Daniel Feirtag</i> DEGREE <i>MD.</i>						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>6-29-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DANIEL FEIRTAG, MD.</i>						22e. ADDRESS <i>BALT CITY HOSPITALS</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>			23b. DATE <i>7/2/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Westview</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTO MD</i>		
24. FUNERAL DIRECTOR NAME ADDRESS <i>Evans Funeral Chapel 8800 Harford Rd</i>						25a. DATE REC'D. BY REGISTRAR <i>JUL 9 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Helen McNeely</i>	

MEDICAL CERTIFICATION

BP

DATE \_\_\_\_\_



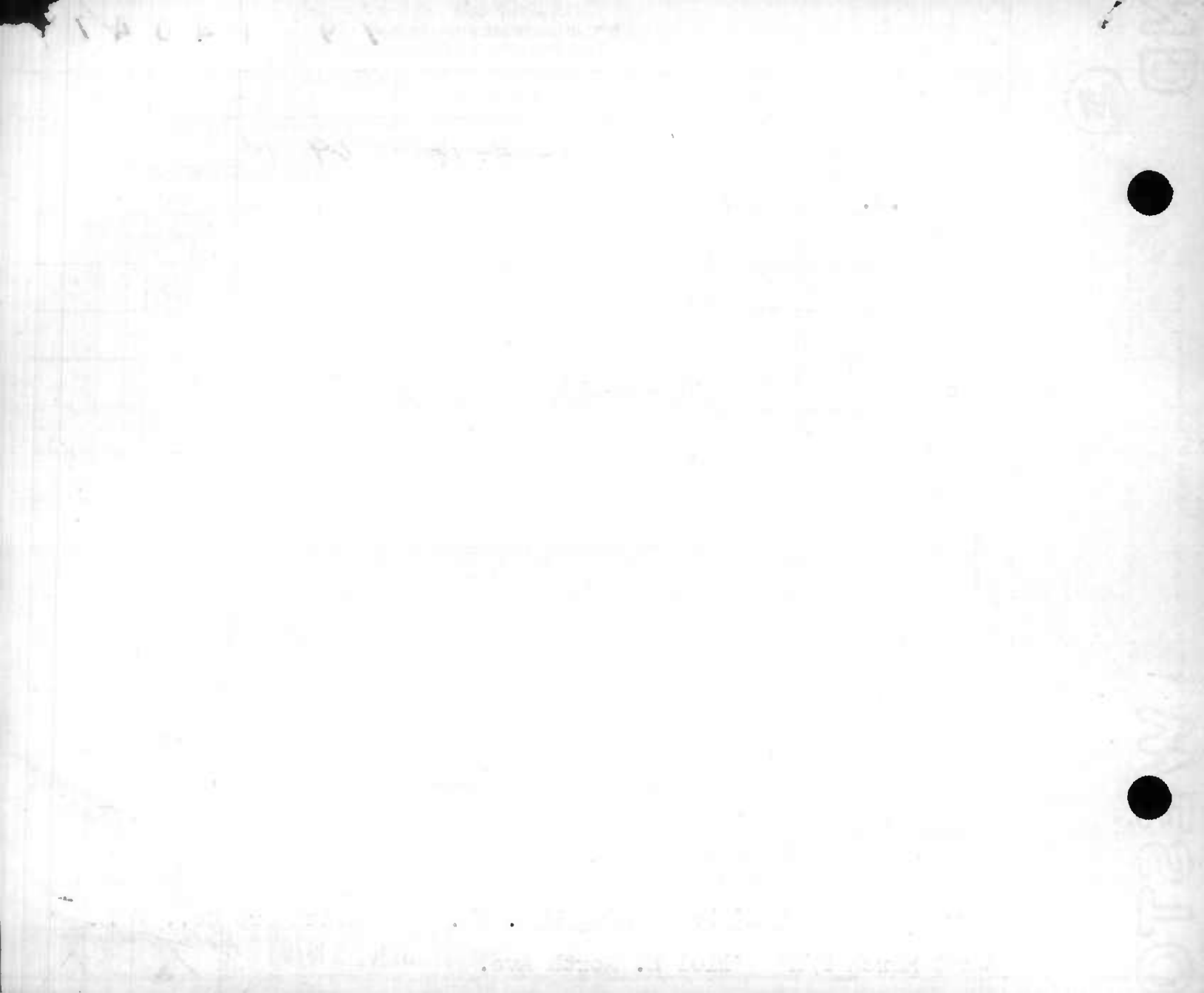
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
FOR STATE REGISTRAR			REG. NO. 14047								
1. DECEASED NAME (TYPE OR PRINT) IDA DAVIS			2a. DATE OF DEATH MONTH DAY YEAR 6-12-79			2b. HOUR 3:15 AM					
3. SEX Female		4. RACE Black.		5. DATE OF BIRTH MONTH DAY YEAR 03-15-10		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balto. Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1442 - Chesapeake Ct. Md. 21226		
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN.								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-60-0759			17. INFORMANT ADDRESS Chart Copy - SBA Hospital.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident C.V.A. 4149 DUE TO, OR AS A CONSEQUENCE OF Ischaemic Heart disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) aspiration pneumonia											
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19 79			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 6-11-1979, to 6-13-1979, that (we) lost saw the deceased alive on 6-12-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE V. R. ARDESHNA, M.D.						22b. DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6-13-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. R. ARDESHNA, M.D.						22e. ADDRESS South Balto. General Hospital.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/16/79		23c. NAME OF CEMETERY OR CREMATORY King Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.				
24. FUNERAL DIRECTOR NAME Wm C March F/H						ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 15 1979		25b. REGISTRAR'S SIGNATURE	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 0 4 8

1. DECEASED NAME (TYPE OR PRINT) <i>Lucille E. DAVIS</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6 3 79</i>			2b. HOUR <i>3:08 PM</i>			
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 7 08</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>71</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Balto.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Provident Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md.</i>			13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Noble Davis</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Maggie</i>			13e. STREET ADDRESS <i>3600 Duvall Avenue</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>			16b. SOCIAL SECURITY NO. <i>577-60-2154</i>		17. INFORMANT ADDRESS <i>Anna Jones 1647 Appleton Street</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO-PULMONARY Arrest.</i> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebro Vascular Accident</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Extensive Decubiti ulcer.</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <i>4/8/79</i> to <i>5/2/79</i> , that (I) (we) last saw the deceased alive on <i>5/2/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>K. Muhallwas</i> DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>6/3/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>KHALID MUHALLWAS</i>						22e. ADDRESS <i>Provident Hosp. BALTO.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>6/7/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Md. Nat. Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Laurel, Md.</i>		
24. FUNERAL DIRECTOR NAME ADDRESS <i>Wm C March F/H 1101 E. North Ave.</i>						25a. DATE REC'D. BY REGISTRAR <i>JUN 5 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Rickey McBrady</i>	

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14049

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Robert		MIDDLE Marshall		LAST Davis		2a. DATE KNOWN OF DEATH		ESTIMATED <input checked="" type="checkbox"/> 6 6 1979		2b. HOUR 6:18 P. M.	
3. SEX male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6/9/1913		6. AGE (IN YEARS) (LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR 6 6 1979		2d. HOUR 6:18 P. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4000 Woodlea Avenue						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Loan Officer		12b. KIND OF BUSINESS OR INDUSTRY Banking			
13a. STATE Maryland		13b. COUNTY -----		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4000 Woodlea Ave., 21206					
14. FATHER'S NAME FIRST MIDDLE LAST James Murray Davis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Roberts									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 216.14.3823		17. INFORMANT ADDRESS Eleanor S. Davis--Same as 13e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 6/7/79	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				111 Penn Street, Balto, MD				21201	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 6/7/1979		23c. NAME OF CEMETERY OR CREMATORY Green Mount				23d. LOCATION CITY OR TOWN Baltimore		COUNTY STATE Md.	
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc.				ADDRESS Balto., Md				25a. DATE REC'D. BY REGISTRAR JUN 11 1979		25b. REGISTRAR'S SIGNATURE Pistay McCreedy			

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FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

14050

1. DECEASED-NAME (Type or print) <b>JAMES N. DAY</b>			2a. DATE OF DEATH Month <b>6</b> Day <b>13</b> Year <b>79</b>			2b. HOUR <b>2:15 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH <b>8/11/06</b>		6. AGE (In years last birthday) <b>73</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Annapolis Co, MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>city Baltimore</b> Md.	
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>University Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Longshoreman</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1154 N Carey St 21217</b>	
14. FATHER'S NAME First Middle Last <b>Aaron Day</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Florence Thomas</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. <b>217 09 3510</b>		17. INFORMANT <b>CORA DAY</b> <b>Chart</b>		Address <b>SAME</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Squamous Cell Cancer lung metastatic to spinal cord.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>HAFT Paraplegia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>29 MAY, 1979</b> , to <b>13 JUNE, 1979</b> , that (I) (we) last saw the deceased alive on <b>13 JUNE 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Jeffrey F Mosser MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/13/79</b>	
22d. PHYSICIAN'S NAME (Type) <b>JEFFREY F. MOSSER</b>				22e. ADDRESS <b>UNIV HOSP BALTO MD 21201</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/18/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. CALVARY Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Aerold Md.</b>	
24. FUNERAL DIRECTOR <b>Vernon Bailey</b>		ADDRESS <b>1348 Calhoun St.</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia Kennedy</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 4 0 5 1		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			7b. HOUR		
Julia SYBIL DAY						June 28 1979			6:25A M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
FEMALE		WHITE		JAN. 11, 1918		61					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
PA.		U.S.A.				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		Maryland General Hospital				P.N.			RETIRED		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
MD.		HARFORD		HARFORD		YES		353 ALLIANCE, ST.			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
CUSTOS S. LINDSEY			MARY L. KAY.								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		267-16-032		WILLARDE, DAY.		SAME					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Probable Pulmonary Embolus</u>											
585- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Renal Failure</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			19 P.M.								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) <del>xxxxxx</del> attended the deceased from <u>April 22</u> , 19 <u>74</u> , to <u>June 28</u> , 19 <u>79</u> , that (1) <del>xxx</del> most saw the deceased alive on <u>June 28</u> , 19 <u>79</u> , and that in (my) <del>xxx</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>xxxxxx</del> did not view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
<u>Cedric Bryan</u>			MD						6-28-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
Cedric Bryan, M.D.			c/o Maryland General Hospital								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
BURIAL			JUNE 30, 1979		ANGEL HILL CEM.		HARFORD, MD.				
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
R. Madison Mitchell, Harford Grace, Md.						JUL 2 1979		<u>Henry McCready</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) REGINALD W. DEARHOLT			2a. DATE OF DEATH MONTH DAY YEAR 6 1 79		2b. HOUR 6-15 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 2 18 1902		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOME 1005 N. CHARLES ST.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	12b. KIND OF BUSINESS OR INDUSTRY -	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY BALTIMORE C.	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1005 NORTH CHARLES ST.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 21716 0093	17. INFORMANT ADDRESS Rhoda Rogers 5927 Green Hill Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> 4392 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIAC ARRHYTHMIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES MINUTES YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (1): <u>(1) DIABETES MELLITUS LATE ONSET (2) PERIPHERAL OCCLUSIVE VASCULAR DISEASE</u>					
19a. DATE OF OPERATION 5-9-79	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ISCHAEMIC LT LOWER EXTREMITY	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 1, 1979</u> to <u>MAY 31, 1979</u> , that (I) (we) lost saw the deceased alive on <u>MAY 31, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Ernesto Molfino</u>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 6/7/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ERNESTO MOLFINO</u>		22e. ADDRESS <u>5653 A HARPER'S FARM RD. COLUMBIA MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/8/79	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME <u>Paul E. Charon</u>		ADDRESS <u>3617 Chestnut Ave.</u>		25a. DATE <u>JUN 11 1979</u>	25b. REGISTERED SIGNATURE <u>John J. McNeely</u>

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 14053	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Edward Paul Dehne</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>6/3/79</b>		2b. HOUR <b>10:45 PM</b>	
3. SEX <b>male M</b>		4. RACE <b>white W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 18, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Trucking Co.</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Essex 21221</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>423 Maryland Ave. 21221</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>George C. Dehne</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary - Fischer</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WWII</b>		17. INFORMANT <b>Richard A. Dehne, nephew</b>		ADDRESS <b>1578 Harford Sq. Drive, Edgewood, Md. 21040</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b> <b>4275</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPTIC SHOCK</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ALCOHOLIC LIVER DISEASE</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>W. Healy MD</b>				DEGREE				22c. DATE SIGNED <b>6/3/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HEALY</b>				22e. ADDRESS <b>BCH</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 5-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Baltimore County, Maryland</b>		STATE			
24. FUNERAL DIRECTOR <b>Bruce J. J. Funeral Home</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 5 1979</b>		25b. SIGNATURE			

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1891-1892, 1893-1894, 1894-1895, 1895-1896, 1896-1897, 1897-1898, 1898-1899, 1899-1900, 1900-1901, 1901-1902, 1902-1903, 1903-1904, 1904-1905, 1905-1906, 1906-1907, 1907-1908, 1908-1909, 1909-1910, 1910-1911, 1911-1912, 1912-1913, 1913-1914, 1914-1915, 1915-1916, 1916-1917, 1917-1918, 1918-1919, 1919-1920, 1920-1921, 1921-1922, 1922-1923, 1923-1924, 1924-1925, 1925-1926, 1926-1927, 1927-1928, 1928-1929, 1929-1930, 1930-1931, 1931-1932, 1932-1933, 1933-1934, 1934-1935, 1935-1936, 1936-1937, 1937-1938, 1938-1939, 1939-1940, 1940-1941, 1941-1942, 1942-1943, 1943-1944, 1944-1945, 1945-1946, 1946-1947, 1947-1948, 1948-1949, 1949-1950, 1950-1951, 1951-1952, 1952-1953, 1953-1954, 1954-1955, 1955-1956, 1956-1957, 1957-1958, 1958-1959, 1959-1960, 1960-1961, 1961-1962, 1962-1963, 1963-1964, 1964-1965, 1965-1966, 1966-1967, 1967-1968, 1968-1969, 1969-1970, 1970-1971, 1971-1972, 1972-1973, 1973-1974, 1974-1975, 1975-1976, 1976-1977, 1977-1978, 1978-1979, 1979-1980, 1980-1981, 1981-1982, 1982-1983, 1983-1984, 1984-1985, 1985-1986, 1986-1987, 1987-1988, 1988-1989, 1989-1990, 1990-1991, 1991-1992, 1992-1993, 1993-1994, 1994-1995, 1995-1996, 1996-1997, 1997-1998, 1998-1999, 1999-2000, 2000-2001, 2001-2002, 2002-2003, 2003-2004, 2004-2005, 2005-2006, 2006-2007, 2007-2008, 2008-2009, 2009-2010, 2010-2011, 2011-2012, 2012-2013, 2013-2014, 2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024, 2024-2025, 2025-2026, 2026-2027, 2027-2028, 2028-2029, 2029-2030, 2030-2031, 2031-2032, 2032-2033, 2033-2034, 2034-2035, 2035-2036, 2036-2037, 2037-2038, 2038-2039, 2039-2040, 2040-2041, 2041-2042, 2042-2043, 2043-2044, 2044-2045, 2045-2046, 2046-2047, 2047-2048, 2048-2049, 2049-2050, 2050-2051, 2051-2052, 2052-2053, 2053-2054, 2054-2055, 2055-2056, 2056-2057, 2057-2058, 2058-2059, 2059-2060, 2060-2061, 2061-2062, 2062-2063, 2063-2064, 2064-2065, 2065-2066, 2066-2067, 2067-2068, 2068-2069, 2069-2070, 2070-2071, 2071-2072, 2072-2073, 2073-2074, 2074-2075, 2075-2076, 2076-2077, 2077-2078, 2078-2079, 2079-2080, 2080-2081, 2081-2082, 2082-2083, 2083-2084, 2084-2085, 2085-2086, 2086-2087, 2087-2088, 2088-2089, 2089-2090, 2090-2091, 2091-2092, 2092-2093, 2093-2094, 2094-2095, 2095-2096, 2096-2097, 2097-2098, 2098-2099, 2099-2100, 2100-2101, 2101-2102, 2102-2103, 2103-2104, 2104-2105, 2105-2106, 2106-2107, 2107-2108, 2108-2109, 2109-2110, 2110-2111, 2111-2112, 2112-2113, 2113-2114, 2114-2115, 2115-2116, 2116-2117, 2117-2118, 2118-2119, 2119-2120, 2120-2121, 2121-2122, 2122-2123, 2123-2124, 2124-2125, 2125-2126, 2126-2127, 2127-2128, 2128-2129, 2129-2130, 2130-2131, 2131-2132, 2132-2133, 2133-2134, 2134-2135, 2135-2136, 2136-2137, 2137-2138, 2138-2139, 2139-2140, 2140-2141, 2141-2142, 2142-2143, 2143-2144, 2144-2145, 2145-2146, 2146-2147, 2147-2148, 2148-2149, 2149-2150, 2150-2151, 2151-2152, 2152-2153, 2153-2154, 2154-2155, 2155-2156, 2156-2157, 2157-2158, 2158-2159, 2159-2160, 2160-2161, 2161-2162, 2162-2163, 2163-2164, 2164-2165, 2165-2166, 2166-2167, 2167-2168, 2168-2169, 2169-2170, 2170-2171, 2171-2172, 2172-2173, 2173-2174, 2174-2175, 2175-2176, 2176-2177, 2177-2178, 2178-2179, 2179-2180, 2180-2181, 2181-2182, 2182-2183, 2183-2184, 2184-2185, 2185-2186, 2186-2187, 2187-2188, 2188-2189, 2189-2190, 2190-2191, 2191-2192, 2192-2193, 2193-2194, 2194-2195, 2195-2196, 2196-2197, 2197-2198, 2198-2199, 2199-2200, 2200-2201, 2201-2202, 2202-2203, 2203-2204, 2204-2205, 2205-2206, 2206-2207, 2207-2208, 2208-2209, 2209-2210, 2210-2211, 2211-2212, 2212-2213, 2213-2214, 2214-2215, 2215-2216, 2216-2217, 2217-2218, 2218-2219, 2219-2220, 2220-2221, 2221-2222, 2222-2223, 2223-2224, 2224-2225, 2225-2226, 2226-2227, 2227-2228, 2228-2229, 2229-2230, 2230-2231, 2231-2232, 2232-2233, 2233-2234, 2234-2235, 2235-2236, 2236-2237, 2237-2238, 2238-2239, 2239-2240, 2240-2241, 2241-2242, 2242-2243, 2243-2244, 2244-2245, 2245-2246, 2246-2247, 2247-2248, 2248-2249, 2249-2250, 2250-2251, 2251-2252, 2252-2253, 2253-2254, 2254-2255, 2255-2256, 2256-2257, 2257-2258, 2258-2259, 2259-2260, 2260-2261, 2261-2262, 2262-2263, 2263-2264, 22

Doc 5-173 10/11/11 10:11 AM

[illegible]

16 DIVISION OF VITAL RECORDS, 701 W. PRESTON ST. BALTIMORE, MARYLAND 21201  
DELANEY SR JOHN LEO  
18719 44  
09 25 13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 7/77  
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 14054	
1. FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) <b>John Leo Delaney, Sr.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>June 24, 1979</b>			2b. HOUR <b>2:08a</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>9 25 1913</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltim ore Md. -City MD.</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Asst. Supr.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Timonium</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>21093 2430 Chetwood Circle Apt. 304</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John A. Delaney</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Reilly</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17 INFORMANT ADDRESS <b>Mrs. Margaret Delaney, 2430 Chetwood Cr.</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> <b>4414</b> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>slp Abdom aortic aneurysm rupture</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>24h</b> <b>3d.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <b>6/20/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Abdom aortic aneurysm</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6/18</u> , 19 <u>79</u> , to <u>6/24</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/24</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.											
22b. SIGNATURE <b>I. Tang</b>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/24/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>I. TANG</b>				22e. ADDRESS <b>J.H.H.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/27/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cockeysville, Md.</b>				
24. FUNERAL DIRECTOR <b>J. E. Lowell Lemmon</b>				ADDRESS <b>10 W. Padonia Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>History McCreedy</b>			







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Steve E Denisuk</b>			2a. DATE OF DEATH MONTH <b>6</b> DAY <b>9</b> YEAR <b>79</b>			2b. HOUR <b>6:05a</b> M				
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>31</b> YEAR <b>95</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St Agnes Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tester</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bethel, Steel</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6722 Youngstown Ave. #21222</b>	
14. FATHER'S NAME FIRST <b>unknown</b> MIDDLE <b>Denisk</b> LAST <b>Denisk</b>			15. MOTHER'S MAIDEN NAME FIRST <b>unknown</b> MIDDLE <b>unknown</b> LAST <b>unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>213-07-3656</b>		17. INFORMANT ADDRESS <b>Mrs. Elaine Shelton 6722 Youngstown Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pre renal Azotemia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Dehydration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Delayed Pneumonia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>A-SEU-D</b> <b>Two strokes</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>May 8</b> , 19 <b>79</b> , to <b>May 9</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>May 8</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Alexandro Mejia MD</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALEXANDRO MEJIA MD</b>			22e. ADDRESS <b>1900 Sulphur Spring Rd 21227</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/12/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Walter Dabrowski</b>			ADDRESS <b>1005 Dundalk Avenue</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 13 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Luttrell McCready</b>		



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST ROBERT	MIDDLE LEE	LAST DENNY	2a. DATE OF DEATH MONTH DAY YEAR June 18, 1979		2b. HOUR 9:30 A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 9, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY A.T.&T. Co.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 911 Marksworth Rd. 21228
14. FATHER'S NAME FIRST MIDDLE LAST William Denny				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Williams				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW1		17. INFORMANT ADDRESS Oreta E. Denny 911 Marksworth Rd. 21228				

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	IMMEDIATE CAUSE (a) <u>Cervical artery dissection</u>	<u>1wk</u>
	DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alcohol related CVD</u>	<u>Perp.</u>
	DUE TO, OR AS A CONSEQUENCE OF (c)	

CERTIFICATION	PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110.</u>			
	<i>hardening of arteries</i>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	

MEDICAL CERTIFICATE	21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> ALONG	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22c. I certify that (I) (this hospital) attended the deceased from <u>Patent No. 10 - K-100, which is a</u> and that (I) (we) last saw the deceased alive <u>in the hospital - where</u> and (I) (we) (did not) view the body after death <u>and death certificate obtained on the date above and from the coroner's office.</u>	
22b. SIGNATURE <u>[Signature]</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <u>6-12-79</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. NELOX McRAY</u>	22e. ADDRESS <u>1132 N. ROLAND RD, BALTE MD. 21228.</u>

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment	23b. DATE 6/21/79	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	23d. LOCATION Pikesville CITY OR TOWN COUNTY BALTO. Md. STATE
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24. FUNERAL DIRECTOR NAME 1630 Edmondson Avenue Baltimore Md. 21228	25a. DATE REC'D. BY REGISTRAR JUN 20 1979	25b. REGISTRAR'S SIGNATURE <i>Robert McCreedy</i>
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TO HOSPITAL ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene in your jurisdiction, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH-16 20M  
(VRA 15, 4) 7/78

02041 61



#16b, Film G532 6/25/79 kam

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 0 5 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Augusta Denow</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>June 10, 1979</i>			2b. HOUR <i>5:30 P.</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>May 12, 1887</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>92</i> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Germany</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Belair Convalesarium</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home Maker</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD.</i>			13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Heinrich Moeller</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Dorothea</i>			13e. STREET ADDRESS <i>3306 Gibbons Ave. - 21214</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>387-48-0046 -</i>		17. INFORMANT ADDRESS <i>Mrs. Esther S. Koerber - 3306 Gibbons Ave. 21214</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1) Arterio Sclerotic Heart Disease</i> <i>4140</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF <i>2) Gangrene of Rt Leg - Amputation</i> DUE TO, OR AS A CONSEQUENCE OF <i>3) Peripheral Vascular Sclerosis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i> <i>6 months</i> <i>8 months</i>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Generalized Arterio Sclerosis</i>									
19a. DATE OF OPERATION <i>4-25-79</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Gangrene Rt Foot</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>None</i> 19 <i>79</i>		21c. HOW INJURY OCCURRED - (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <i>None</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>100 - W. Bold Spring Lane</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>June 10</i> , 19 <i>79</i> , to <i>June 10</i> , 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>June 6/2</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE <i>Earl R. Chambers MD</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>6/11/79</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Earl L. Chambers</i>	
22e. ADDRESS <i>100 - W. Bold Spring Lane</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6-15-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Riverside Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Oshkosh, Wisconsin</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>John C. Miller Inc - 6415 Belair Rd. - 21206</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 13 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Anthony Maloney</i>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 0 5 8

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Alfred Wadsworth DEREMER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-19-1979</b>		2b. HOUR <b>7:40 a.m.</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10-28 1914</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>64 years</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (CITY OR TOWN OF COUNTY) <b>N.Y. STRINGFIELD GARDENS</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City.</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bus Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Limousines</b>
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>A.A. Co.</b>	13c. CITY OR TOWN <b>Glen Burnie</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILBER DEREMER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LILLIAN COX</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>W.W.H. 107-07-8833</b>	17. INFORMANT ADDRESS <b>ELEANOR JEAN DEREMER 8102 MONTAGUE CT. GLEN BURNIE 21061, MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>RENAL FAILURE</b> <b>185-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMATOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARCINOMA PROSTATE w/ METASTASES</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>5-18-</b> 19 <b>79</b> , to <b>6-19-</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6-18-</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>S. Pathmanathan</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6-19-1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sivakolunthunathan Pathmanathan</b>		22e. ADDRESS <b>South Baltimore General Hospital, Baltimore, M.D. 21230.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>6-22-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREENMOUNT CEM.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>GREENMOUNT AVE. BALTO. 21202, MD</b>		24. FUNERAL DIRECTOR NAME <b>Charles S. Gilew &amp; Son, Inc.</b> ADDRESS <b>901 S. CONKING ST. BALTO. 21224, MD.</b>			
25a. DATE REC'D. BY REGISTRAR <b>JUN 21 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 14059	
1. DECEASED NAME (TYPE OR PRINT) <b>FRANK JOHN DERUS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June-24-1979</b>			2b. HOUR <b>3:47 A.M.</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04-02-05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTO General HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Dundalk</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7803 New Battle Grove Rd.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN DE RUS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY ANNA DERUS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214 03 1688</b>		17. INFORMANT <b>7803 New Battle Grove Rd.</b> <b>Gertrude H. Derus - Balto. MD 21222</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic failure - Micronodular</b> 5715 DUE TO, OR AS A CONSEQUENCE OF (b) <b>coronary - Portal hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Generalized arteriosclerosis, severe</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <b>6-14-1979</b> to <b>6-24-1979</b> , that (we) lost saw the deceased alive on <b>6-24-1979</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>V. R. ARDESHIVA</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>6-24-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>V. R. ARDESHIVA</b>				22e. ADDRESS <b>South Balto. Gen. Hospital.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/27/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Stanislaus</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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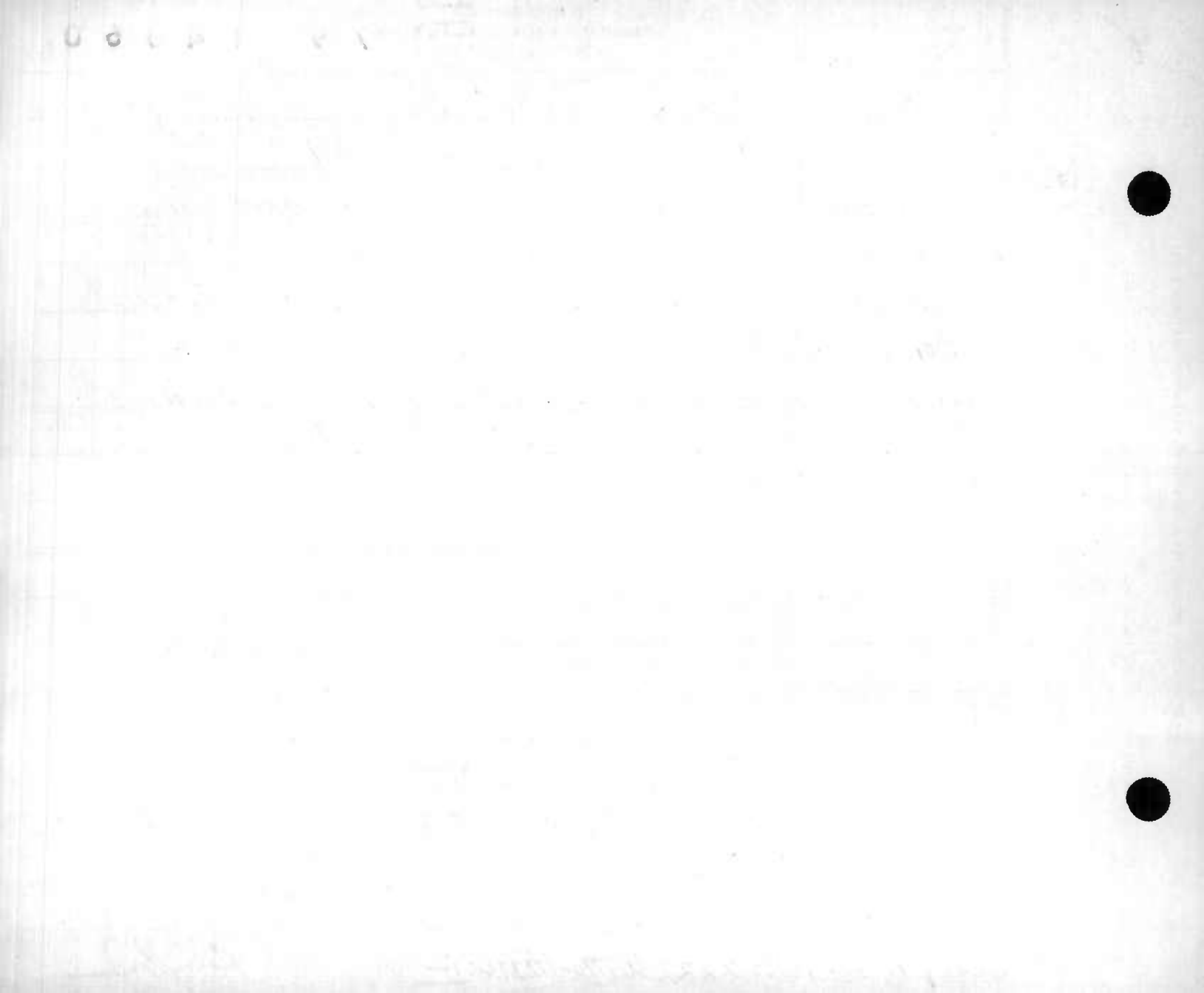
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 1 4 0 6 0  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Kenneth Lloyd Deshields</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>6-7-79</b>		2b. HOUR <b>4a</b> M
3 SEX <b>male</b>	4 RACE <b>Col</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3-20-18</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Mem. Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>		13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>John Edward Deshields</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Keason Belle</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>214-03-7727</b>		17 INFORMANT ADDRESS <b>Mrs. Ruth Boston 3702 Dorchester Rd.</b>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Inborn Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sum</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7:17-18</b> P.M. 19 <b>79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>369/79</b>
22. I certify that (I) (this hospital) attended the deceased from <b>7/17/78</b> 19 <b>79</b> , to <b>3/6/79</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>3/6/79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22a. SIGNATURE <b>DR. Mark Duban</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED <b>9/11/79</b>
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. MARK DUBAN</b>		22d. ADDRESS <b>15E. Biddle St.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-12-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge Memorial</b>
24 FUNERAL DIRECTOR NAME <b>Joseph L. Russ</b>		ADDRESS <b>2222 W. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1979</b>
				25b. REGISTRAR'S SIGNATURE <b>Barbara K. Brady</b>



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>BESSIE DICKS</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>6-26-79</u>		2b. HOUR <u>11 A M</u>	
3 SEX <u>FEMALE</u>		4 RACE <u>BLACK</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>6-30-07</u>		
6 AGE (IN YEARS LAST BIRTHDAY) <u>71</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.						
10 CITY OR TOWN OF DEATH <u>Balto.</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Lutheran Hosp.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
12b. KIND OF BUSINESS OR INDUSTRY						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <u>Md.</u>		13b. COUNTY		13c. CITY OR TOWN <u>Balto.</u>		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>801 Wilbert Avenue</u>				
14 FATHER'S NAME FIRST MIDDLE LAST <u>Samuel Williams</u>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Margaret Myers</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>215-05-6754</u>		17 INFORMANT ADDRESS <u>Alice Cooper 9115 Gary Lane</u>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>4292</u> IMMEDIATE CAUSE (a) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>?</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>RESIDUALS RESECTION OF BRAIN TUMOR</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>6-26</u> , 19 <u>79</u> , to <u>6-26</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-26</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Thomas W. Harris, MD</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>6-27-79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>THOMAS W. HARRIS, MD</u>		22e. ADDRESS <u>4200 EDMONDSON AVE BALTIMORE MD</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>6/30/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest Cem.</u>		
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Towson, Md.</u>						
24. FUNERAL DIRECTOR NAME <u>Wm C March F/H</u>		ADDRESS <u>1101 E. North Ave.</u>		25a. DATE REC'D. BY REGISTRAR <u>JUL 2 1979</u>		
25b. REGISTRAR'S SIGNATURE <u>Henry McBrady</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR REGISTRAR									
I. DECEASED NAME (TYPE OR PRINT) <b>SUZIE DIGGS</b>					2a. DATE OF DEATH MONTH <b>6</b> DAY <b>22</b> YEAR <b>79</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>29</b> YEAR <b>1886</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b>		7b. HOUR <b>6:30</b> P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maid</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Apt. Building</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1213 N. Bentalou St.</b>	
14. FATHER'S NAME FIRST <b>William</b> MIDDLE LAST <b>Daniels</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE LAST <b>Anderson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>179-03-1781</b>		17. INFORMANT ADDRESS <b>A Miss Rosamond Diggs 1213 N. bentalou</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> <b>4275</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>6/17</b> , 19 <b>79</b> , to <b>6/22</b> , 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>6/22</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Thomas S. Trinchetto</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>6/22/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS S. TRINCETTO</b>					22e. ADDRESS <b>BCH, 4440 EASTERN AVE, BALT. MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 27, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Saints Rest Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>Herbert E. Nutter 3035 W. North Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Brady</b>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 6 AND 7 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14063

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Sophia FRANCES Dilabio</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6 8 1979		2b. HOUR M 3:46 PM
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 20 15</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>63</b> YRS.	IF UNDER 1 YR. MONTHS DAYS <b>63</b>
7a. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>232 S. Chapel Street</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF Employed Produce Store</b>
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md.</b>		13b. CITY <b>CITY</b>	13c. CITY OR TOWN <b>BALTO.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK BIALOBRZESKI</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>TERESA ANNA DOLIWA</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-24-9677</b>		17. INFORMANT ADDRESS <b>ANTHONY F. DILABIO 9 S. LIGHT ST.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>Margarita A. Korell</b>		TITLE (SPECIFY) <b>Assistant</b>		DATE SIGNED <b>6/10/79</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>		ADDRESS <b>111 Penn Street</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>6-12-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. Co. md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>WM. FIALKOWSKI - 2007 EASTERN AVE.</b>		25a. DATE RECD. BY REGISTRAR <b>JUN 14 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony F. Dilabio</b>

MEDICAL CERTIFICATION

C O C K A T



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 7 9 1 4 0 6 4			
1. DECEASED NAME (TYPE OR PRINT) <b>Joseph DiNicolò</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6 5 79</b>			
3. SEX <b>Male</b>				4. RACE <b>White</b>			
5. DATE OF BIRTH MONTH DAY YEAR <b>1 31 11</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>ST AGNES HOSPITAL</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TAILOR</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>OAKLOOM</b>			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>			
13c. CITY OR TOWN <b>Baltimore</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS <b>1720 Spence Street, 21230</b>				13f. CLOTHES			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Anthony DiNicolò</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucia DiGiorio</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO <b>212-01-8369</b>			
17. INFORMANT ADDRESS <b>Marie M. Cayer, 1934 Griffiths Avenue</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiogenic Shock from (b)</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/5/79</b> <b>10 A.M.</b> to <b>3-40 P.M.</b> and (I) (we) lost the deceased alive on <b>6/5/79</b> at <b>3-40 P.M.</b> and (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>P. VANKINGENI M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6/5/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. VANKINGENI</b>				22e. ADDRESS <b>St. Agnes Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>06-08-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.,</b>				ADDRESS <b>21229 4107 Wilkens Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 6 1979</b>	
						25b. REGISTRAR'S SIGNATURE <b>P. VANKINGENI</b>	

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ST. LOUIS CITY

ST. LOUIS HOSPITAL

ST. LOUIS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 14065						
1. DECEASED NAME (TYPE OR PRINT) Robert J. Dischinger Jr.			2a. DATE OF DEATH MONTH DAY YEAR 6/20/79				2b. HOUR 2:30 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 20, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 56		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Data Control		12b. KIND OF BUSINESS OR INDUSTRY Chessie System	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15. STREET ADDRESS 1220 Longford Road	
14. FATHER'S NAME FIRST MIDDLE LAST Robert J. Dischinger, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marion O'Brien						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) XXXXX Yes			16b. SOCIAL SECURITY NO. WWII 214-14-8766		17. INFORMANT ADDRESS Rebecca B. Dischinger, Same As #13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from 6/17, 19 79, to 6/20, 19 79, that (I) (we) last saw the deceased alive on 6/20, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE B.K. Yankoff MD			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					22c. DATE SIGNED 6/20/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin Yankoff			22e. ADDRESS Union Memorial Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-23-79		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto. Md.		
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204					25a. DATE REC'D. BY REGISTRAR JUN 22 1979		25b. REGISTRAR'S SIGNATURE Anthony M. Brady		

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1. The first part of the report is a summary of the work done during the year.

2. The second part is a detailed account of the work done during the year.

3. The third part is a summary of the work done during the year.

4. The fourth part is a detailed account of the work done during the year.

5. The fifth part is a summary of the work done during the year.

6. The sixth part is a detailed account of the work done during the year.

7. The seventh part is a summary of the work done during the year.

8. The eighth part is a detailed account of the work done during the year.

9. The ninth part is a summary of the work done during the year.

10. The tenth part is a detailed account of the work done during the year.

11. The eleventh part is a summary of the work done during the year.

12. The twelfth part is a detailed account of the work done during the year.

13. The thirteenth part is a summary of the work done during the year.

14. The fourteenth part is a detailed account of the work done during the year.

15. The fifteenth part is a summary of the work done during the year.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					79 14066				
1. DECEASED NAME (TYPE OR PRINT)					7a. DATE OF DEATH				
FIRST MIDDLE LAST William Disney					MONTH DAY YEAR 06 27 79				
3. SEX					7b. HOUR				
Male					8A - M				
4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			8. IF UNDER 1 YEAR	
White		MONTH DAY YEAR May 16, 1907			72 years YRS.			IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		U.S.A.			Baltimore City, MD.			Forklift Operator Acme Market	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		3116 Mareco Avenue			Forklift Operator			Acme Market	
13a. STATE					13b. COUNTY				
Md.					Baltimore				
13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?				
Catonsville					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST Unknown Unknown					FIRST MIDDLE LAST Unknown Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
NO					212-12-0053				
17. INFORMANT					ADDRESS				
Mr. Hilton F. Smedley,					21207 1406 Clairidge Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>									1 day
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive C.V.D.</i>									10 yr.
DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
none			—			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
			P.M. 19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct</i> 19 <i>58</i> , to <i>June</i> 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>6-28</i> 19 <i>79</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Dr. J. Duer Moores M.D.</i>						DEGREE		22c. DATE SIGNED	
						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<i>6-29-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
Dr. J. Duer Moores, M.D.						3105 Belair Road			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			6/30/79		Lorraine Park Cemetery		Baltimore County, Maryland		
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hubbard Funeral Home, Inc.						4107 Wilkens Ave. Balto., Md. 21229		<i>Jun 29 1979</i>	

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove co-bonopapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 79 14067									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Dunbar		Distance						6-18-79		11:45 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		BLACK		2-12-1903		76 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
BALTIMORE MD		USA				BALTIMORE, City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALT. MD.		1720 E. 31st Street						Retired Postal			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
MARYLAND				BALTIMORE				1720 E. 31st Street			
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)									
Dunbar		Samuel Distance		Carrie Young							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		213-05-2199A		Doris Distance		1720 E. 31st St.					
18. CAUSE OF DEATH (Enter only one cause per line for 4a, b, and c. PART I. DEATH WAS CAUSED BY.)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) intracranial bleeding											
430- DUE TO, OR AS A CONSEQUENCE OF (b) cerebral aneurysm											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6/18/79 to 6/18/79, that (I) (we) lost saw the deceased alive on 6/18/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
Francisco J. Criado		6/18/79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Francisco J. Criado		Union Memorial Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		6-22-79		Cedar Hill Cemetery		ANNE ARUNDEL Co. Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
William J. Spicer		1639 N. Broadway		JUN 20 1979		[Signature]					

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please mail it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or inhumation. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 1 4 0 6 8 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Guy ELMER DIXON XXXXXXXXXX				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR JUNE 28, 1979 1:15 AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 23, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 7. UNDER 1 YEAR 8. UNDER 24 HRS. 78 MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Dairy Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. STATE Maryland 13b. COUNTY Frederick 13c. CITY OR TOWN Frederick				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 915 North Market Street			
14. FATHER'S NAME FIRST MIDDLE LAST Charles DIXON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) XXXXXXXXXXXX 220-16-0507		17. INFORMANT ADDRESS Mrs. May Dixon 915 North Market Street Frederick, Md. 21701			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4241 CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 6/1/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED AORTIC STENOSIS		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/31, 1979, to 6/28, 1979, that (I) (we) lost saw the deceased alive on 6/27, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE I. M. Rutkow MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/28/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) I. M. Rutkow, MD				22e. ADDRESS Baltimore, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-30-1979		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.	
24. FUNERAL DIRECTOR'S NAME Robert E. Dalley & Son				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 5 1979			
25c. ADDRESS 1201 N. Market St. Frederick, Md. 21701							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 7914069						
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
JOSEPH S. DLUGOKENSKI			JUNE 14, 1979			M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
MALE		WHITE		MONTH DAY YEAR 1 17 93		86		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
POLAND		USA				BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		915 S. OLDHAM ST.				steel worker		Bethel, Steel	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS		
MARYLAND					BALTIMORE		915 S. OLDHAM ST. #21224		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST ? Dlugokenski			FIRST MIDDLE LAST unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
no			217 01 2863			Siegmond Dlugokenski 915 S. Oldham Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Stroke Syndrome</u>									
436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Organic Brain Syndrome</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Central Adrenocortical</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>1-16</u> 19 <u>77</u> to <u>5-24</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5-24</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			22b. SIGNATURE <u>R. Perez-Mera</u> DEGREE <u>M.D.</u> MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>6-15-79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
DR. GAUJAR			5400 OLD COURT RD., RANDALLSTOWN, MD 21133						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		6/18/79		Meadowridge Memorial		Baltimore		Maryland	
24. FUNERAL DIRECTOR NAME				25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Walter Dabrowski				1005 Dundalk Avenue		JUN 25 1979		<u>Henry McBrady</u>	



1 17 93 80

steel worker      Bethel, Stead

unknown

Dingokanski

317 01 1883      Sigmund Dingokanski 912 S. Oldham Street

no

9/13/73      Keahonridge Memorial      Baltimore      Maryland

1005 Dundalk Avenue      Dundalk, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, the certificate should be detached for use as the Burial Transmittal. Then please remove carbon copies of pages 1, 2, and 3 and file them in the death record book. The original of this certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - STATE REGISTRAR			REG. NO.			79 14070			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RYAN AUSTIN DOBBS</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 21, 1979</b>		2b. HOUR <b>5:54PM</b>	
3. SEX <b>Male</b>		4. RACE <b>Cau</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Mar 5, 1978</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>1 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE, CITY MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins University Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>n/a</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>n/a</b>	
13a. STATE <b>Virginia</b>		13b. COUNTY <b>Fairfax</b>		13c. CITY OR TOWN <b>Annandale</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7125 Jayhawk Street 22003</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Dana R Dobbs</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sharon D Dobbs</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>n/a</b>		17. INFORMANT <b>Father, Same address as deceased</b>		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypersensitive reaction</b> <b>2706</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ornithine Transcarbamylase Deficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Deficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>15 mo</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from <b>3/1/79</b> , 19 <b>79</b> , to <b>6/21</b> , 19 <b>79</b> , that (I) (we) saw the deceased alive on <b>6/21</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Patricia L.H. Quinn</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/21/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Patricia L.H. Quinn</b>				22e. ADDRESS <b>Johns Hopkins Hospital, Baltimore</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>June 24, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematorium</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D C</b>			
24. FUNERAL DIRECTOR NAME <b>Halden Arnold</b>				ADDRESS <b>Demaine Funeral Home, Alexandria, Va 22314</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																			
1. FOR STATE REGISTRAR		7. REG. NO.		9 14071															
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
VINCENT (Waters)				DODSON						6		19		79		3:20P		M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS									
MALE		BLACK		1 1 19		60 YRS		MONTHS		DAYS		HOURS		MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
CALVERT, MD.		U.S.A.				BALTIMORE CITY													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
BALTIMORE		VA MEDICAL CENTER BALTO.MD.				Md. State													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
MARYLAND				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3032 HARLEM AVENUE											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Ernest		Ottis		Dodson		Elsie		Chase											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
YES		WW II		217-01-5336		Amelia Dodson		3032 Harlem Ave.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pancreatic cancer</u> 1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JUNE 1, 19 79</u> to <u>JUNE 19, 19 79</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>JUNE 19, 19 79</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> not interview the body after death.																			
22b. SIGNATURE				DEGREE				22c. DATE SIGNED											
<u>Kendall R. Faulkner MD</u>								6/19/79											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS															
KENDALL R. FAULKNER				3900 LOCH RAVEN BLVD. BALTO.MD. 21218															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				6/25/79				Arbutus Mem. Pk.				Arbutus, Md.							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Wm C March F/H				1101 E. North Ave.				JUN 22 1979				<u>Liskey McBrady</u>							

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DHMH-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

This body released to Chambers Funeral Home, Moorefield, W.Va. 26836

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		7 9 1 4 0 7 2		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
FANNYE		M		DOMAN				6		30		79	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
female		white		May 29, 1905		74		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
W.Va.		USA				BALTIMORE CITY						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Balto.		THE JOHNS HOPKINS HOSPITAL		housewife		at Home							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
W.Va.		Hardy		Baker		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		rural					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Thomas		J. Hawse		Francelia		Davidson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
no		unknown		Chambers Funeral Home		Moorefield, W.Va.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>respiratory arrest</u>													
2030 DUE TO, OR AS A CONSEQUENCE OF (b) <u>multiple myeloma</u>										8 months			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (this hospital) attended the deceased from <u>6/3/79</u> 19 <u>79</u> to <u>6/30</u> 19 <u>79</u> that (we) last saw the deceased alive on <u>6/30/79</u> 19 <u>79</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
Mark C. Mitchell, M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		6/30/79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
MARK C. MITCHELL		JOHNS HOPKINS HOSPITAL											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial		7/3/79		Asbury Cem.		Baker, Hardy, W.Va.							
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
SLACK Funeral Home, Ellicott City, Maryland 21043						JUL 2 1979		Turkey McCreedy					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 4 0 7 3				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> Catherine <sup>MIDDLE</sup> Dorsey <sup>LAST</sup>					2a. DATE OF DEATH MONTH DAY YEAR 6-1-79			2b. HOUR 2:45 <sup>M</sup>	
3. SEX F		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 2-22-04		6. AGE (IN YEARS LAST BIRTHDAY) 75		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto City MD.			
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Security		12b. KIND OF BUSINESS OR INDUSTRY Retired	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Md.		13b. COUNTY -		13c. CITY OR TOWN Balto.		13e. STREET ADDRESS 213 E. Preston St. 21202			
14. FATHER'S NAME <sup>FIRST</sup> unknown <sup>MIDDLE</sup> <sup>LAST</sup>					15. MOTHER'S MAIDEN NAME <sup>FIRST</sup> Mary <sup>MIDDLE</sup> <sup>LAST</sup>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 212-07-3409		17. INFORMANT ADDRESS Mrs. Nellie V. Wilson 2601 Hamilton Ave.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>shen moria</u> 5621 DUE TO, OR AS A CONSEQUENCE OF (b) <u>sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>diverticulosis / diverticulitis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>RSCVD / DxD</u>									
19a. DATE OF OPERATION 5/18/79 - 5/25/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED massive renal bleeding				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/18 19 79, to 6/1 19 79, that (I) (we) last saw the deceased alive on 6/1 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John C. Miller</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/1/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. C. MILLER					22e. ADDRESS MERCY HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-4-79		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. - Md.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 5 1979	
24. FUNERAL DIRECTOR NAME John C. Miller Inc. 6415 Belair Rd.					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 5 1979				

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Dorothy C. Dorsey</b>			2a. DATE OF DEATH <b>6/21/79</b> Month Day Year			2b. HOUR M				
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>3/20/27</b>		6. AGE (In years last birthday) <b>52</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto City</b> Md.				
10. CITY OR TOWN OF DEATH <b>Balto.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>739 N. Fulton Ave.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>City</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>739 N. Fulton Ave.</b>	
14. FATHER'S NAME <b>John Chase</b>			15. MOTHER'S MAIDEN NAME <b>Nora Gaither</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown)			16b. SOCIAL SECURITY NO. <b>217-20-1794</b>		17. INFORMANT Address <b>Donald Brown 5337 Nelson Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Esophagus</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Barth G. Uehle, M.D.</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) <b>Festo Mlela M.D.</b>				22e. ADDRESS <b>2525 Eutaw Place</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>6/26/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Arbutus Co. Md.</b>				
24. FUNERAL DIRECTOR <b>Charles A. Rice 1300 Eutaw Place</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barth G. Uehle</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 118 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 1 4 0 7 5 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) MILTON T. DORSEY					2a. DATE OF DEATH MONTH DAY YEAR 06 28 79 2b. HOUR 5:14A.M.				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 06 14 11		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL - E.R.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST		12b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN ARBUTUS					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1033 CIRCLE DRIVE, 21227		
14. FATHER'S NAME FIRST MIDDLE LAST MILTON DORSEY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET BRANSBY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 215-03-0966		17. INFORMANT ADDRESS MARIE I. DORSEY, 1033 CIRCLE DRIVE, 21227			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture Abdominal Aneurysm 4413 } DUE TO, OR AS A CONSEQUENCE OF (b) H.A.S. C. V.D. - O.P.D. - Shunt (c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/23 1979 to 6/28 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death.)									
22b. SIGNATURE E. M. RAMOS, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/28/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 4000 ANNAPOLIS ROAD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 06-30-79		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.,				ADDRESS 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR JUN 29 1979		25b. REGISTRAR'S SIGNATURE Barney K. Brady	

MEDICAL CERTIFICATION



EXHIBIT 1

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535



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EXHIBIT 1

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

1- STATE REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14076

1. DECEASED NAME (TYPE OR PRINT)		FIRST VICTOR		MIDDLE M.		LAST DORSEY		2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR				2b. HOUR			
3 SEX male		4 RACE black		5. DATE OF BIRTH MONTH DAY YEAR 10-21-59		6. AGE (IN YEARS) LAST BIRTHDAY 19 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 5 3 19 79		2d. 55 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.									
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Marketer				12b. KIND OF BUSINESS OR INDUSTRY DCA Foods			
13a. STATE Md.		13b. COUNTY Howard		13c. CITY OR TOWN MARIOTTVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 11273 Old Frederick Rd.							
14. FATHER'S NAME Raymond C. Dorsey				15. MOTHER'S MAIDEN NAME Miriam Wilson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-74-6260		17. INFORMANT Miriam Dorsey				ADDRESS MARIOTTVILLE, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot wound of head (Hand Gun)</u> 9850 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 5/31 19 79				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) shot by police							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street				21i. LOCATION STREET CITY OR TOWN COUNTY STATE 1300 Bl. Edmondson Sts. Baltimore Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>															
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) Assistant				DATE SIGNED 5/3/79							
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-7-79		23c. NAME OF CEMETERY OR CREMATORY St. Alphonsus Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Chestock Balb. Md.					
24. FUNERAL DIRECTOR NAME Harry W. Haight				ADDRESS Sykesville, Md.				25a. DATE REC'D. BY REGISTRAR MAY 9 1979				25b. REGISTRAR'S SIGNATURE Loring McBrady			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 1 4 0 7 7 REG. NO.	
1. FOR STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY H. DOTSON			2a. DATE OF DEATH MONTH DAY YEAR JUNE 28, 1979		2b. HOUR 4:00A <sub>M</sub>
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 4 19 33	6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. COUNTY	13c. CITY OR TOWN Balto.	13d. STREET ADDRESS 3702 Edgewood Rd.
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Dotson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Gladden		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean 219-30-2979	17. INFORMANT ADDRESS Gertrude Brown 3702 Edgewood Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Distress Syndrome</u> 486- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/17</u> , 19 <u>79</u> , to <u>6/27</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/27</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Kenneth Marek</u>		DEGREE		22c. DATE SIGNED 6/27/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth Marek		22e. ADDRESS Johns Hopkins Hosp			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/2/79	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.
24. FUNERAL DIRECTOR NAME Wm C. March F/H		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 29 1979	25b. REGISTRAR'S SIGNATURE <u>Robert M. Kelly</u>

14077

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

TO: Mr. J. H. ...

FROM: Mr. J. H. ...

SUBJECT: ...

DATE: ...

PLACE: ...

REMARKS: ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 4 0 7 8			
1- FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
JAMES		W.		DOTSON				6		5	79	5	45 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
MALE		WHITE		JULY 28, 1928		50 YEARS		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OF COUNTY OF DEATH							
VIRGINIA		U.S.A.				BALTIMORE CITY, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
BALTIMORE		BON SECOURS HOSPITAL		SOLDIER		U.S. ARMY							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. COUNTY		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS					
VA.								ROUTE 1					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
EMORY		DOTSON		MAGGIE		BREEDING							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR DATE)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
YES		KOREAN		MR. FINNEY, LEBANON FUNERAL HOME, BOX 216		LEBANON, VA. 24266							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		303- ASPIRATION PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		1 DAY					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF		GRAND MAL SEIZURES		5 DAYS							
		DUE TO, OR AS A CONSEQUENCE OF		CHRONIC ALCOHOLISM		YEARS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		ACUTE PANCREATITIS											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.		5-30 19 79 to 6-05 19 79		that (I) (we) lost									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
Oscar E. Fernandez M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		6-06-79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
OSCAR E. FERNANDINI M.D.		2025 W. FAYETTE ST. BALTO. MD. 21223											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
BURIAL		6/8/79		DYE FAMILY CEMETERY		RUSSELL COUNTY, VIRGINIA							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
HUBBARD FUNERAL HOME, INC.		4107 WILKENS AVE.		JUN 8 1979									

BP

876189

3



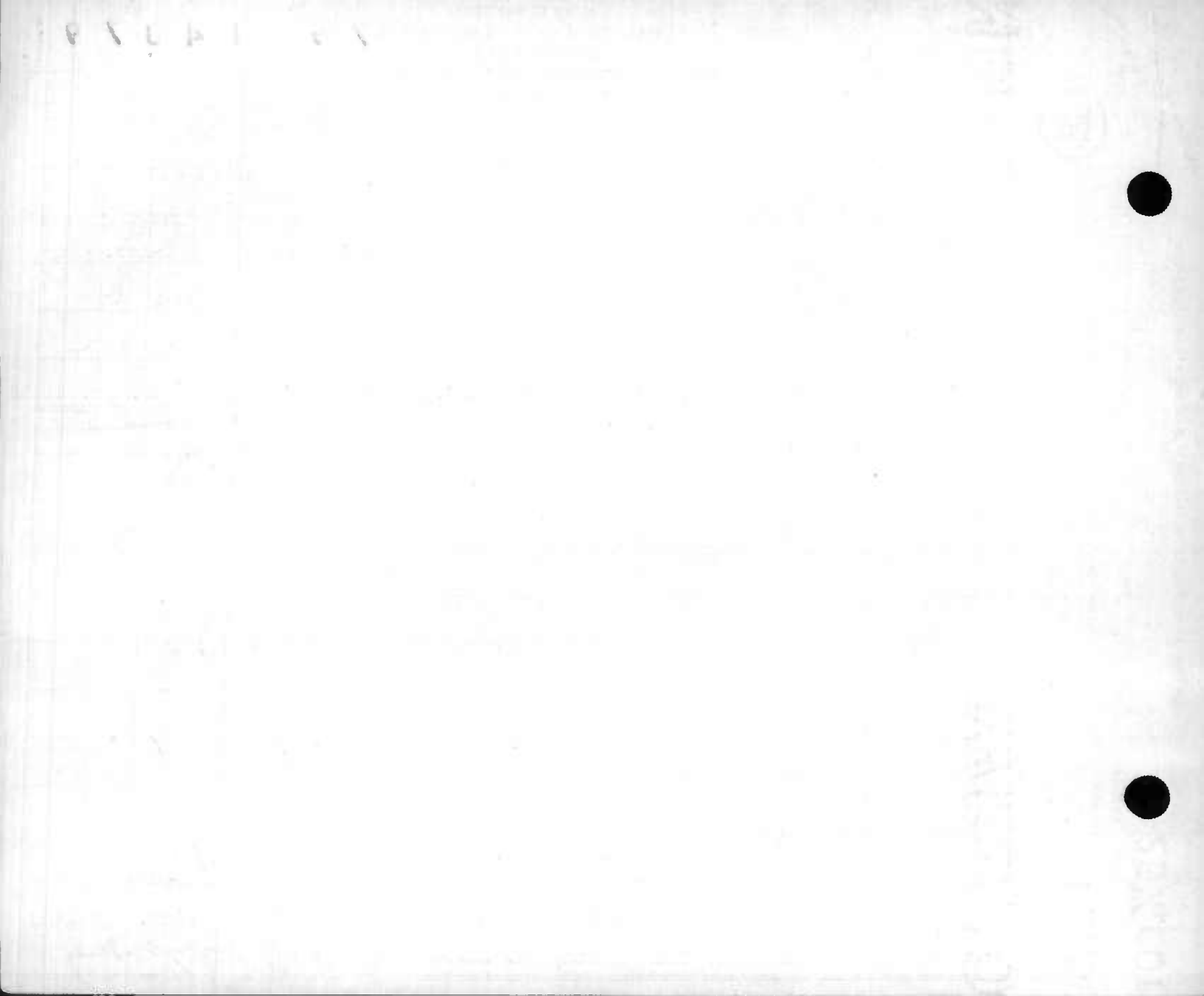
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
John P. Dougherty		6 27 79	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Male	W	9 9 20	58
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Pa. U.S.A.	U.S.A.		Baltimore
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Univ. of Md. HSP.	Policeman	Balto. City
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. INSIDE CITY LIMITS?	13c. STREET ADDRESS	
Md. Balto.	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	4649 Leisner Ct.	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		
John Dougherty	Maudie Snyder		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
YES	WWII	Robert J. Dougherty, 13701 Alliston Dr. 21013	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardio pulmonary failure</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4241 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>post Aortic Valve Replacement</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aortic Valve disease</u>			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
6/25/79	Aortic stenosis	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
	P.M. 19		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>6/23</u> 19 <u>79</u> to <u>6/27</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/27</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE	DEGREE	22c. DATE SIGNED	
Abdulla Attu	M.D.		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
Abdulla Attu	Univ. of Md. HSP.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	6-29-79	Druid Ridge Cemetery	Pikesville, Balto. Maryland
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Ruck Towson Funeral Home, Inc.		JUN 20 1979	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
Towson, Md. 21204		[Signature]	



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH-16 50M 7/77  
(VR A 15 (4))

Items 21a. -21f. & 22a.		STATE OF MARYLAND		7914080	
1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		6914080	
as		CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
RAYMOND DOUGLAS		JUNE 30, 1979		6:05 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		Black		MONTH DAY YEAR	
				1 21 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
N.C.		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
				BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Balto.		THE JOHNS HOPKINS HOSPITAL		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.				Balto.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Scott		Philiss McCoy		No	
				16b. SOCIAL SECURITY NO.	
				216-18-3791	
				17. INFORMANT	
				Theodis Douglas	
				ADDRESS	
				3935 Flowerton Rd.	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3481 Anoxic Brain Damage		4 days			
DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Arrest					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Aspiration					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
Sepsis 2° to Urinary Tract Infection					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/16/79 to 6/30/79, that (I) (we) lost the deceased alive on 6/30/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Natural		22b. SIGNATURE		22c. DATE SIGNED	
		Laurence S. Friedman, MD		6/30/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
LAURENCE S. FRIEDMAN		Johns Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		7/3/79		Baltimore Cem.	
				23d. LOCATION CITY OR TOWN COUNTY STATE	
				Baltimore, Md.	
24. NAME		34. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Wm C March F/H		1101 E. North Ave.		JUL 2 1979	
				25b. REGISTRAR'S SIGNATURE	
				[Signature]	

14080



RECEIVED  
JUN 20 1951

6:00

JUN 20 1951

DOUGLAS

RAYMOND

AMERICAN CITY

THE JOHNS HOPKINS HOSPITAL

101 W. BALTIMORE

BALTIMORE

MCCOY

THOMAS

DOUGLAS

2nd

100% CO  
JUN 20 1951



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 14081							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CLEMENT B. DOVE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 10, 1979</b>			2b. HOUR <b>12:05P</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 27 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>66</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PAINTER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BALTO. CITY</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE <b>MD.</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTO.</b>		13e. STREET ADDRESS <b>5002 OLIVER ST.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>334-01-7827</b>		17. INFORMANT ADDRESS <b>MARY DOVE (WIFE) SAME ADDRESS</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 410- DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>274</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Ventricular Tachycardia</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/10</b> , 19 <b>79</b> , to <b>6/10</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/10</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>K. Mark</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>6/10/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kenneth Mark</b>				22e. ADDRESS <b>Johns Hopkins Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/13/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLLY HILL CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>			
24. FUNERAL DIRECTOR NAME <b>SCHIMUNEK FUNERAL HOME, INC.</b>				25. ADDRESS <b>3321 BREHMS LANE BALTO. MD. 21213</b>		26. DATE REC'D. BY REGISTRAR <b>JUN 11 1979</b>		27. REGISTRAR'S SIGNATURE <b>R. H. Roberts</b>	

18041

18041



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79	14082
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST Rose	MIDDLE L.	LAST Doxzen	2a. DATE OF DEATH		MONTH 6	DAY 4	YEAR 79	2b. HOUR 3:48 PM	
3. SEX Female		4. RACE C		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS 73 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Md.				13b. COUNTY --		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST Harrison				15. MOTHER'S MAIDEN NAME FIRST Mary		13e. STREET ADDRESS 943 W. Lombard Street					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 213-32-7980		17. INFORMANT ADDRESS Harrison					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory arrest 431-- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Left cerebral hemorrhage (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Congestive Heart Failure											
19a. DATE OF OPERATION --		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED --				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6/3, 1979, to 6/4, 1979, that (I) (we) lost saw the deceased alive on 6/4, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Mark J. Kushner MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 6/4/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark J. Kushner MD				22e. ADDRESS University of Maryland Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 6/7/79		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JUN 13 1979		25b. REGISTRAR'S SIGNATURE H. H. H. H.			



2801-1-1



2801-1-1

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 0 8 3

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ANITA M. Dozier			2a. DATE OF DEATH MONTH DAY YEAR 6 8 79			2b. HOUR 7:00 AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 30 89		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4515 St. Georges Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Smith		16. STREET ADDRESS 4515 St. George's Ave.			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		17b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OF DATES) 216-16-3197		17. INFORMANT ADDRESS Marguerite Dixon 4515 St. George's Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1 Recurrent stroke</u> 436- DUE TO, OR AS A CONSEQUENCE OF: (b) <u>2 ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <u>3 Coma</u> DUE TO, OR AS A CONSEQUENCE OF: PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/20 19 79</u> to <u>6/8 19 79</u> that (I) (we) last saw the deceased alive on <u>6/11 19 79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Nguyen</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/8/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VUONG NGUYEN				22e. ADDRESS 1656 E. Belvedere ave APT 821209			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/12/79		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 12 1979	
						25b. REGISTRAR'S SIGNATURE <u>Robert McBrady</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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**NOTICE TO HOSPITAL OR ATTENDING PHYSICIAN**

The undersigned hereby certifies that the following patient has been retained by the hospital or attending physician:

PATIENT'S NAME: **DEAPER, FAITH D**

DATE OF BIRTH: **10 06 77**

ROOM NO.: \_\_\_\_\_

WARD NO.: \_\_\_\_\_

CLINICAL HISTORY: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

LOCATION: \_\_\_\_\_

REMARKS: \_\_\_\_\_

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Physician's Title

\_\_\_\_\_  
Hospital Name

\_\_\_\_\_  
Address

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City

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State

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Zip

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Other Contact Information

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Signature of Hospital Representative

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Title of Hospital Representative

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Name of Hospital Representative

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Address of Hospital Representative

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City of Hospital Representative

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State of Hospital Representative

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Zip of Hospital Representative

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Phone of Hospital Representative

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E-mail of Hospital Representative

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Internet of Hospital Representative

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Other Contact Information of Hospital Representative

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Signature of Patient Representative

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Title of Patient Representative

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Name of Patient Representative

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Address of Patient Representative

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Other Contact Information of Patient Representative

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Signature of Funeral Director

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Title of Funeral Director

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Name of Funeral Director

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Other Contact Information of Funeral Director

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Signature of Burial Transit Permit Issuer

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Title of Burial Transit Permit Issuer

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Name of Burial Transit Permit Issuer

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Address of Burial Transit Permit Issuer

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City of Burial Transit Permit Issuer

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Other Contact Information of Burial Transit Permit Issuer

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Signature of State Dept. of Health and Mental Hygiene

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Title of State Dept. of Health and Mental Hygiene

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Name of State Dept. of Health and Mental Hygiene

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Address of State Dept. of Health and Mental Hygiene

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Other Contact Information of State Dept. of Health and Mental Hygiene

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Signature of Medical Examiner

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Title of Medical Examiner

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Name of Medical Examiner

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Other Contact Information of Medical Examiner

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Signature of Coroner

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Other Contact Information of Coroner

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Signature of Other Official

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Other Contact Information of Other Person

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Signature of Other Person



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 4 0 8 4

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. <div style="font-size: 2em; margin-top: -10px;">14084</div>				
1. DECEASED NAME (TYPE OR PRINT) <div style="display: flex; justify-content: space-between;"><span>FIRST FAETH</span><span>MIDDLE D</span><span>LAST DRAPER</span></div>										2a. DATE OF DEATH MONTH DAY YEAR JUNE 13 1979										2b. HOUR 3:30 P.M.				
3. SEX Female			4. RACE Negro			5. DATE OF BIRTH MONTH DAY YEAR October 6, 1977				6. AGE (IN YEARS LAST BIRTHDAY) 1 YRS.				# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS. HOURS MIN								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD														
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A				12b. KIND OF BUSINESS OR INDUSTRY										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																								
13a. STATE Delaware			13b. COUNTY			13c. CITY OR TOWN Wilmington			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2818 Jefferson Street												
14. FATHER'S NAME FIRST MIDDLE LAST Frank Draper			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Robinson																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. —			17. INFORMANT ADDRESS W.M. James Leake, F.H./N.E. Cor: 10th & Pusey Sts. Pa.																		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK 7456 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) REPAIR OF A-V CANAL (c) A-V CANAL / CONGESTIVE HEART FAILURE 19 mos										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3H SH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
19a. DATE OF OPERATION 6/13/79					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED A-VCANAL										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from JUNE 11 19 79, to JUNE 13 19 79, that (I) (we) lost saw the deceased alive on JUNE 13 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE Christopher S. McCullough M.D.										DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					22c. DATE SIGNED 6/14/79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTOPHER S. MCCULLOUGH										22e. ADDRESS THE JOHNS HOPKINS HOSPITAL														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Burial					23b. DATE 06/18/1979					23c. NAME OF CEMETERY OR CREMATORY Haven Memorial Park					23d. LOCATION CITY OR TOWN COUNTY STATE Chester Township, Penna.									
24. FUNERAL DIRECTOR Marshall W. Jones, Jr., F.H./4101 Edmondson Ave. W.M. Leake, F.D./S.E. Cor. 10th & Pusey Sts. Chester										25a. DATE REC'D. BY REGISTRAR JUN 30 1979					25b. REGISTRAR'S SIGNATURE Lipman									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										9	1	4	0	8	5
1- FOR STATE REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DANIEL A. DROWSKY										2a. DATE OF DEATH MONTH DAY YEAR 06 07 79				2b. HOUR 10 <sup>45</sup> AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 1, 1929				6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.									
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. City Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Union							
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 607 S. Streeper St.							
14. FATHER'S NAME FIRST MIDDLE LAST Walter J. Drowsky		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nabel Carneal													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-26-3577		17. INFORMANT Iris Drowsky		ADDRESS 607 S. Streeper St.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DO TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Lung Carcinoma</u> DO TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Since 9/78															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>none</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>June 7<sup>th</sup> 1979</u> to <u>June 9<sup>th</sup> 1979</u> , that (I) (we) last saw the deceased alive on <u>June 7<sup>th</sup> 1979</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Kenneth L. Glick		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 6/7/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth L. Glick MD		22e. ADDRESS Baltimore City Hospital													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-11-79		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.									
24. FUNERAL DIRECTOR NAME Thelma A. Hoffmann		ADDRESS 3218 Hudson St.		25a. DATE REC'D. BY REGISTRAR JUN 12 1979		25b. REGISTRAR'S SIGNATURE Ruthy McBrady									



680415



5 187 68 72

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 0 8 6

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Spring Marie Drury</b> <b>Baby Girl Drury</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>June 25, 1979</b>		2b. HOUR <b>10:26p</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 20, 1979</b>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <b>5</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Drury</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Glenda Keefer</b>		16. STREET ADDRESS <b>423 Clarendon Ave.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Mr. Thomas Drury Hag. Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b> 7597 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metabolic Acidosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Multiple Congenital Anomalies</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10:26 PM</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/20</b> , 19 <b>79</b> , to <b>6/25</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/25</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Sharon</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/26</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SHARON</b>		22e. ADDRESS <b>John Kybur Holtz</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 27, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clearspring, Wash. Md.</b>	
24. FUNERAL DIRECTOR (NAME) <b>Donald E. Thompson</b>		24b. ADDRESS <b>Thompson Funeral Home</b>		24c. CITY OR TOWN <b>Clearspring, Md.</b>		25a. DATE REG'D. BY REGISTRAR <b>JUL 2 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>Anthony M. Brady</b>							



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

14087

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Costello C. Dudley			2a. DATE OF DEATH MONTH DAY YEAR 6 13 79		2b. HOUR M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1 29 12		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 74 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4319 Marble Hall Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 4319 Marble Hall Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST James Dudley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Coleman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-09-4256		17. INFORMANT ADDRESS Norman Dudley 1529 Kingway	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Right Internal Carotid Rupture - Shock</u> 6/13/79 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recurrent Carcinoma of Larynx - Pharynx</u> 4/2/79 DUE TO, OR AS A CONSEQUENCE OF (c) <u>Status Post Laryngectomy + Radiotherapy</u> 6/21/78 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 6/21/78		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Larynx		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Hubert G. Skinner, MD				22c. DATE SIGNED 6/15/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hubert G. SKINNER, MD				22e. ADDRESS 2300 Garrison Blvd Balt. Md 21216	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/19/79		23c. NAME OF CEMETERY OR CREMATORY King Mem. Pk.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.					
24. FUNERAL DIRECTOR NAME Wm C March F. H.		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 18 1979	
25b. REGISTRAR'S SIGNATURE P. J. Brady					



*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "right", "left", and "center" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 1 4 0 8 8 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Florence G. Duke					2a. DATE OF DEATH MONTH DAY YEAR 6-30-79			2b. HOUR 2:15 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 29, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Nat'l cleaning window	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. A.A. Glen Burnie					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 12 Birch Ave. (21061)		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Hanes					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Butz				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 216-03-2181		17. INFORMANT ADDRESS Rev. James R. Duke (same as 13e)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Astrocystoma grade III</u> 1919 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Leah M. Vaughan MD					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6/30/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/5/1979		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore		
24. FUNERAL DIRECTOR NAME ADDRESS George J. Gonce, 4001 Ritchie Hg., Baltimore					25a. DATE REC'D. BY REGISTRAR JUL 3 1979		25b. REGISTRAR'S SIGNATURE Rita J. Kahan		

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP \_\_\_\_\_  
DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		7 9 1 4 0 8 9		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NATALIE H. DUNN			2a. DATE OF DEATH MONTH DAY YEAR 6 7 79		2b. HOUR 1:30 PM
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11-20-1898	6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hostess		12b. KIND OF BUSINESS OR INDUSTRY Restaurant
13a. STATE Maryland		13b. COUNTY Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3234 Abel Ave
14 FATHER'S NAME FIRST MIDDLE LAST John Humphrey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 219-62-4183		17. INFORMANT ADDRESS Sue Fenwick 521 Laurel Ave, Fredricksburg Va, 22401	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension, R. CVA, Carcinoma of lung</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>ACVD</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE E. MAGROS MD		DEGREE		22c. DATE SIGNED 6/7/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. MAGROS MD.		22e. ADDRESS UNION Memorial Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-9-79		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem	
23d. LOCATION CITY OR TOWN Baltimore		COUNTY Baltimore		STATE Maryland	
24 FUNERAL DIRECTOR Mitchell-Wiedefeld Homr		ADDRESS 6500 York Rd. 21212		25a. DATE REC'D. BY REGISTRAR JUN 11 1979	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIOLA Florence DUNN			2a. DATE OF DEATH MONTH DAY YEAR 6-20-79		2b. HOUR 5 <sup>10</sup> P.M.
3. SEX F	4. RACE CAU	5. DATE OF BIRTH MONTH DAY YEAR 1-23-14	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					
13b. COUNTY Balto.		13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 7505 Berkshire Rd. 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Petrus C. Ruil, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Guise		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218.01.7311	17. INFORMANT ADDRESS Margaret A. Hare--Same as 13e		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 431- PROBABLE INTRACEREBRAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) COPD					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/20 1979 to 6/20 1979, that (I) (we) last saw the deceased alive on 6/20 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
27b. SIGNATURE A. Snello M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		27c. DATE SIGNED 6/20/79	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA A. SNELLO		27e. ADDRESS MERCY HOSP.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/23/1979	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Md.	
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc., Dundalk, Md.		25a. DATE REC'D. BY REGISTRAR JUN 22 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

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U.S. DEPARTMENT OF JUSTICE

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 14091

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES H. DUNSON</b>			2a. DATE OF DEATH MONTH <b>6</b> DAY <b>25</b> YEAR <b>79</b> 2b. HOUR <b>8:15 AM</b>		
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>Dec.</b> DAY <b>24</b> YEAR <b>1908</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS IF UNDER 1 YEAR: MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b> IF UNDER 24 HRS: MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sign Artist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employ</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST <b>Howard</b> MIDDLE <b>Dunson</b> LAST <b>Dunson</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Mamie</b> MIDDLE <b>Moore</b> LAST <b>Moore</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-10-6991</b>		17. INFORMANT ADDRESS <b>Mrs. Mildred Dunson 501 Dolphin St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHEROSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Uremia, Carcinoma Prostate; anemia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b>A.M.</b> MONTH <b>19</b> DAY <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>6-23</b> , 19 <b>79</b> , to <b>6-25</b> , 19 <b>79</b> , that (1) (we) lost saw the deceased alive on <b>6/23</b> , 19 <b>79</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>M. J. Shafi</b>		DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAVAD M SHAFI</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 29, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>	
23d. LOCATION CITY OR TOWN <b>Baltimore Co.</b> COUNTY <b>Maryland</b> STATE					
24. FUNERAL DIRECTOR NAME <b>Herbert E. Nutter</b>		ADDRESS <b>3035 W. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>H. E. Nutter</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

19041



NOTED

June 27, 1904  
1904

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 14092

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles C. Duval			2a. DATE OF DEATH MONTH DAY YEAR 6 6 79		2b. HOUR 4:15 PM
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12 03 02	6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sonai		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus Drive	12b. KIND OF BUSINESS OR INDUSTRY City	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY Balt	13c. CITY OR TOWN Balt	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 616 S. Brandy St	
14. FATHER'S NAME FIRST MIDDLE LAST Duval		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <del>213-10-1327</del> 213-10-1327		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Peripheral & cerebral vascular disease.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 3/29, 19 79, to 6/6, 19 79, that (1) I saw the deceased alive on 6/6, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.					
22b. SIGNATURE James H. Pickar		DEGREE MD		22c. DATE SIGNED 6/6/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James H. Pickar		22e. ADDRESS Sonai			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 6/6/79		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR JUN 8 1979			
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25b. REGISTRAR'S SIGNATURE Lillian M. Brady	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14093

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14093			
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE KNOWN OF DEATH				3. HOUR			
Dwayne Edmonds								X MONTH DAY YEAR 6 6 1979				A			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		4:30 P M	
Male		Black		4 30 56		23		MONTHS DAYS HOURS MIN.				6 6 1979			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
D.C.				U. S. A.								Baltimore City			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK OR OF LAST WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore City				University Hospital				LABORER				NONE			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE				13b. COUNTY				13c. CITY OR TOWN			
				MARYLAND				PRINCE GEORGE				FORRESTVILLE			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
JOHN R. EDMONDS				BLONNIE ATCHESON				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2522 SENATOR AVENUE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
								BLONNIE R. EDMONDS				2522 SENATOR AVE.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8811 IMMEDIATE CAUSE (a) Cranio cerebral trauma Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11xx 6 5 19 79				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject fell from scaffold							
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) building site				21f. LOCATION CITY OR TOWN COUNTY STATE Johns Hopkins Rd Crofton A.A. MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 6/7/79							
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEM. CEMETARY				23d. LOCATION CITY OR TOWN COUNTY STATE SUTLAND, P. G. G MARYLAND			
24. FUNERAL DIRECTOR NAME JOHN T. RHINES CO., 3015 12th ST., N.E., D.C.				25a. DATE REC'D. BY REGISTRAR JUN 7 1979				25b. REGISTRAR'S SIGNATURE							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 14094			
1. DECEASED NAME (TYPE OR PRINT) <b>Bernard Edwards</b>				2a. DATE OF DEATH MONTH <b>6</b> DAY <b>12</b> YEAR <b>79</b>			
3 SEX <b>male</b>		4 RACE <b>caucasian</b>		5 DATE OF BIRTH MONTH <b>07</b> DAY <b>30</b> YEAR <b>94</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of Maryland Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balt</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS <b>2632 Collage Ave</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>218-03-2924</b>		17 INFORMANT ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction of small bowel &amp; colon.</b> (b) <b>Superior mesenteric artery Thrombosis.</b> (c) <b>5576</b> DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15-h. approx.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <b>6/12/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Acute Abdomen</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/11/79</b> , 19 <b>79</b> , to <b>6/12</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/12</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>G. Y. Apostolides</b> DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/12/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. Y. APOSTOLIDES</b>				22e. ADDRESS <b>U. MD. Hosp.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>6-14-79</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board 655 W. Baltimore St.</b> ADDRESS				25a. DATE REC'D. BY REGISTRAR <b>JUN 18 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony M. Brady</b>	

REPORT

(M)

RECEIVED

NOV 10 1950





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VR 15 (4) 9/74)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 14095

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE ELLEN LAST ELLIOTT			2a. DATE OF DEATH MONTH 6 DAY 9 YEAR 1979		2b. HOUR 12:10 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 7 DAY 8 YEAR 1895		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER PA. AVENUE NURSING CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE KEEPER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY CALVERT 13c. CITY OR TOWN BROOMES ISLAND 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS OYSTER HOUSE ROAD					
14. FATHER'S NAME FIRST JAMES MIDDLE R. LAST ELLIOTT			15. MOTHER'S MAIDEN NAME FIRST VICTORIA MIDDLE ELLIOTT LAST ELLIOTT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-18-5665		17. INFORMANT MYRTLE V. ROBERTS		ADDRESS 20678 PRINCE FREDERICK, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension - cellulitis of lips								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from 1-23 1979 to 6-9 1979, that (I) (we) last saw the deceased alive on 6-9 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (do not) view the body after death.								
22b. SIGNATURE R.O. CROSBY		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-9-79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.O. CROSBY		22e. ADDRESS 936 W. North Ave Balto						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUNE 11, 1979		23c. NAME OF CEMETERY OR CREMATORY BR. IS. CEMETERY		23d. LOCATION CITY OR TOWN BROOMES IS. COUNTY CALVERT STATE MD.		
24. FUNERAL DIRECTOR NAME DONALD V. BORGWARDT ADDRESS PORT REPUBLIC, MD.				25a. DATE REC'D. BY REGISTRAR JUN 14 1979		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79 14096			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MIRIAM A ELLIS				2a. DATE OF DEATH MONTH DAY YEAR JUNE 4, 1979			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 13 1926		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 52 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cafeteria		12b. KIND OF BUSINESS OR INDUSTRY School	
13a. STATE Md.				13b. COUNTY Carroll		13c. CITY OR TOWN Manchester	
14. FATHER'S NAME FIRST MIDDLE LAST Charles A. Shorb				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Markle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-22-9010		17. INFORMANT ADDRESS Mr. M. Ward Ellis, Manchester, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 1749 DUE TO, OR AS A CONSEQUENCE OF (b) hypercalcemia 3 months DUE TO, OR AS A CONSEQUENCE OF (c) metastatic breast cancer 2 years.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from June 1, 1979, to June 4, 1979, that (1) we last saw the deceased alive on June 4, 1979, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (1) we (1) did not view the body after death.							
22b. SIGNATURE Charles G. Helmick MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED June 4, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles G. Helmick				22e. ADDRESS 6159 Parkway Dr #1, Balt, Md. 21212			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-7-79		23c. NAME OF CEMETERY OR CREMATORY Immanuel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Manchester Carroll Md.	
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074				25a. DATE REC'D. BY REGISTRAR JUN 11 1979		25b. REGISTRAR'S SIGNATURE Helen M. Mendenhall	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 4 0 9 7	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
MARTIN B. EMERICK JR.						6-27-79			6:10 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS	
Male		W		1-29-18			61 YRS.				
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			11. BALTIMORE CITY OR COUNTY OF DEATH			12. BALTIMORE CITY MD.	
Md		USA					BALTIMORE CITY				
13. CITY OR TOWN OF DEATH			14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			16. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE			ST AGNES HOSPITAL			CARPENTER			PARKWAY CONST.		
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			18. CITY OR TOWN			19. INSIDE CITY LIMITS?			20. STREET ADDRESS		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET ADDRESS		
MARYLAND			BALTIMORE			CATONSVILLE			267 E. MEDWICK GARTH, 21228		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. INFORMANT			17. ADDRESS		
MARTIN B. EMERICK SR.			LETTIE B. HUGHES			MARTIN B. EMERICK, III			GARTH, 21228		
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			18b. SOCIAL SECURITY NO.			19. INFORMANT			20. ADDRESS		
YES			WW II			218-03-4640			MARTIN B. EMERICK, III; 267 E. MEDWICK		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Staphylococcal pneumonia.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>5-2-</u> 19 <u>79</u> to <u>6-27-</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-27-79</u> at <u>6:10 A.M.</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (TYPE OR PRINT)		
<u>Purand S. Vankineni</u>			M.D.			6/27/79			P. VANKINENI		
22e. ADDRESS			22f. ADDRESS			22g. ADDRESS			22h. ADDRESS		
St. Agnes Hospital			St. Agnes Hospital			St. Agnes Hospital			St. Agnes Hospital		
Baltimore MD-21229			Baltimore MD-21229			Baltimore MD-21229			Baltimore MD-21229		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN		
BURIAL			06-29-79			WOODLAWN CEMETERY			WOODLAWN		
24. FUNERAL DIRECTOR NAME			24. ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
HUBBARD FUNERAL HOME, INC.,			4107 WILKENS AVE.			JUN 28 1979			<u>Kathy McBrady</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9	1 4 0 9 8
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Theresa Englander</b>					2a. DATE OF DEATH MONTH <b>June</b> DAY <b>13</b> YEAR <b>1979</b>					2b. HOUR <b>1230</b> PM	
3. SEX <b>FEMALE</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>13</b> YEAR <b>1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1044 FLAGTREE LA. #21208</b>			
14. FATHER'S NAME FIRST <b>BENJAMIN</b> MIDDLE <b></b> LAST <b>BLOCK</b>					15. MOTHER'S MAIDEN NAME FIRST <b>JENNIE</b> MIDDLE <b></b> LAST <b>WERTHEIMER</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>101-10-0494</b>		17. INFORMANT <b>MRS. HELENE BLUM</b> <b>1044 FLAGTREE LANE BALTO., MD 21208</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Respiratory Failure</b> <b>496-</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>COPD - Rheumatoid lung disease</b> Years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CHF</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b></b> A.M. MONTH <b></b> DAY <b></b> YEAR <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>							
22a. I certify that (this hospital) attended the deceased from <b>6-8</b> , 19 <b>79</b> , to <b>6-13</b> , 19 <b>79</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>6-13-</b> , 19 <b>79</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.											
22b. SIGNATURE <b>Sheila A. Walker</b> MD					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <b>13 June 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SA WALKER</b>					22e. ADDRESS <b>SINAI HOSPITAL</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL</b>		23b. DATE <b>JUNE 14, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HUNGARIAN UNION FIELD</b>				23d. LOCATION CITY OR TOWN <b>SOC. TOWN. BROOKLYN</b> COUNTY <b></b> STATE <b>NEW YORK</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Ruby K. Brady</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

14099

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LAURIN ETUE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6/28/79</b>			2b. HOUR <b>3:15 A.M.</b>				
3 SEX <b>F</b>		4 RACE <b>C</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 30 78</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>0</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>8 28</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.				
10 CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md</b>			13b. COUNTY		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>RONALD ETUE</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LINDA ?</b>			13e. STREET ADDRESS <b>Mt. Wash. Peds Hosp Inc.</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17 INFORMANT <b>Ronald Etue</b>				ADDRESS <b>6908 Rawhide Ridge Columbia</b>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> <b>7597</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>multiple Congenital Deformities</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Microcephaly, Cleft Lip and Palate</b>										
19a. DATE OF OPERATION <b>—</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we, (did) (did not) view the body after death.										
22b. SIGNATURE <b>Susan V. Prevas</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>6/28/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SUSAN V. PREVAS</b>					22e. ADDRESS <b>SINAI HOSPITAL BALTO., MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>June 29/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Louis</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clarksville Howard Md.</b>			
24. FUNERAL DIRECTOR <b>Harry H. Witzke</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 2 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Harry H. Witzke</b>			

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Agnes G. Etzel</b>									
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 9, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>		7. DATE OF DEATH MONTH DAY YEAR <b>June 25, 1979</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>		2b. HOUR <b>5:30 P.M.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Jenkins Memorial</b>				12a. USUAL OCCUPATION (TYPE OF WORK, SOLE SOURCE OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>2708 Pelham Avenue</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Morwood</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Casey</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-10-4462D</b>		17. INFORMANT ADDRESS <b>Mr. William F. Etzel 2708 Pelham Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic degenerative</b> <b>4370</b> DUE TO, OR AS A CONSEQUENCE OF <b>cerebrovascular disease</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>med</b> , 19 <b>78</b> , to <b>6-25</b> , 19 <b>79</b> , that (he) (she) last saw the deceased alive on <b>6-25</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Laurence R. Gallager</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>6-26-79</b>	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Laurence R. Gallager</b>				22e. ADDRESS <b>St. Agnes Memorial Center</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-29-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. 5305 Harford Rd. Balto; Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 27 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Richard H. B...</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 1 0 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MAMIE E. MIDDLE EVANS LAST			2a. DATE OF DEATH MONTH DAY YEAR 6/6/79		2b. HOUR 10:30 AM
3 SEX FEMALE	4 RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 06 16 1895		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY N	
13a. STATE Md.			13b. COUNTY Baltimore	13c. STREET ADDRESS 2217 Eutaw Place 21217	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Roscoe M. Evans, 2217 Eutaw Place	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Renal failure</u> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <u>UTI and di</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>diabetes</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Mc Dermott MD</u>		DEGREE MD		22c. DATE SIGNED JUN 6 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. WHITE /S/ SWISHER		22e. ADDRESS 900 CATON AVE. BALTIMORE, MD. 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/12/79	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR Law Funeral Home 4611 Park Heights Ave.			25a. DATE REC'D. BY REGISTRAR JUN 11 1979		25b. REGISTRAR'S SIGNATURE <u>Barney McBrady</u>

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 1 4 1 0 2			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Margaret Mildred Ewing				2a DATE OF DEATH 6 1 79		2b HOUR 8:25 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH July 12, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 71 years	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (AND IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Receptionist		12b KIND OF BUSINESS OR INDUSTRY Lutheran Hosp.	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Baltimore		13c. CITY OR TOWN Arbutus	
14 FATHER'S NAME Louis				15. MOTHER'S MAIDEN NAME Mary Edna Clark			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO. 220-58-1745		17 INFORMANT Mrs. Mary Jane McGowan, 4419 Linden Avenue	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 496- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) X <u>Congestive heart failure</u>							
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? X YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>6-25</u> 19 <u>79</u> to <u>6-1</u> 19 <u>79</u> , that (I) (we) lost X saw the deceased alive on <u>June 6-1</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE X <u>Huan-Jane Hsu</u>				DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) X <u>Huan-Jane Hsu</u>				22e. ADDRESS <u>St. Agnes Hosp. 900 Caton Ave. 21209</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/4/79		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland	
24 FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.				25a DATE REC'D. BY REGISTRAR JUN 4 1979		25b REGISTRAR'S SIGNATURE <u>L. J. Brady</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 4 1 0 3 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE E. LAST FELDER						2a. DATE OF DEATH MONTH DAY YEAR 06 20-79		2b. HOUR 7:32 P.M.	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 06 01 79		6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS.		7. IF UNDER 1 YEAR UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3718 Beehler Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Saul Robinson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carmielia Wake					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 231-36-3597		17. INFORMANT ADDRESS Inez Boone 3718 Beehler Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) PNEUMONIA 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 06-16-79, to 06-20-79, that (I) (we) lost saw the deceased alive on 06-20-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Cesar E. Gamboa M.D.				DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 06-20-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CESAR E. GAMBOA, M.D.				22e. ADDRESS 90 SINAI HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/25/79		23c. NAME OF CEMETERY OR CREMATORY Liberty Hill AME Ch		23d. LOCATION CITY OR TOWN COUNTY STATE Clardon, S.C.			
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 22 1979		25b. REGISTRAR'S SIGNATURE Ruthy McCreedy	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER A. FELDMAN						2a. DATE OF DEATH MONTH DAY YEAR 06 29 79			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 05 14 02		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		2b. HOUR 0130 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1190 W. NORTHERN PARKWAY, APT. 406				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) attorney		12b. KIND OF BUSINESS OR INDUSTRY AT LAW	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13e. STREET ADDRESS APT. 406 1190 W. Northern Pkwy. #21210			
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH FELDMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE BEARMAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. FIELD SECURITY NO. WWII-ARMY 215-22-8341		17. INFORMANT ADDRESS MRS. LORRIANE FELDMAN 1190 W. NORTHERN PKWY., APT. 406 #21210			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory arrest secondary to acute M.I. DUE TO OR AS A CONSEQUENCE OF (b) Biventricular rheumatic heart disease with mitral regurgitation DUE TO OR AS A CONSEQUENCE OF (c) ASCVD with CHF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) gastrointestinal bleeding									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from April 4, 1979, to June 29, 1979, that (I) (we) last saw the deceased alive on June 28, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles S. Angell M.D.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles S. Angell, M.D.				22e. ADDRESS 611 Park Avenue Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JULY 1, 1979		23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR JUL 3 1979		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

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UNITED STATES AIR FORCE

MEMORANDUM

TO :

FROM :

SUBJECT :

REFERENCE :

REMARKS :

REMARKS :

REMARKS :

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79 14105			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Cornelius Ferguson</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6-12-79</b>			
3. SEX <b>Male</b>				2b. HOUR <b>9.55 A M</b>			
4. RACE <b>Negro</b>				5. DATE OF BIRTH MONTH DAY YEAR <b>-1885</b>			
6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS				7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore, Md.</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hosp</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE PRECEDENCE BEFORE ADMISSION) 13b. COUNTY <b>Md Baltimore</b>				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13d. STREET ADDRESS <b>1136 N. Carey St.</b>				13e. STREET ADDRESS <b>1136 N. Carey St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob Ferguson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lizzie Fields</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>212-05-5325</b>			
17. INFORMANT <b>BELLE FERGUSON</b>				ADDRESS <b>1136 N. Carey St. Baltimore, Md.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4029 Congestion Heart failure</b> IMMEDIATE CAUSE (a) <b>4029</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days.</b> <b>years.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6-12</b> , 19 <b>79</b> to <b>6-12</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6-12</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Sujeta Sapsiri</b>				22c. DATE SIGNED <b>6-12-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SUJETA SAPSIRI</b>				22e. ADDRESS <b>Lutheran Hospital of Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6/16/79</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Vernon R. Bailey</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1979</b>			
25b. REGISTRAR'S SIGNATURE <b>R. H. Bailey</b>							

20141

*[Faint, illegible handwriting on lined paper]*

*[Faint, illegible handwriting at bottom left]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 14106			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2e. DATE OF DEATH MONTH DAY YEAR				7b. HOUR	
HELEN Louise FIELDS								June 17, 1979				10:35P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 10, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 68		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Church			
13a. STATE Md		13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1327 Weldon Avenue					
14. FATHER'S NAME FIRST MIDDLE LAST William E. Fields				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Green									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 36 7817		17. INFORMANT Edna R. Miller / James Miller				ADDRESS 21222 6819 Boston Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> <u>179-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenosquamous carcinoma of the uterus with</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>widespread metastases</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1X) this hospital attended the deceased from <u>June 17, 1979</u> to <u>June 17, 1979</u> , that (X) (we) lost saw the deceased alive on <u>June 17, 1979</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Renee Waschler</u>				DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>6/17/79</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Renee Waschler, M.D.</u>				22e. ADDRESS <u>c/o Maryland General Hospital</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>6/20/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Woodlawn Balto. Md</u>							
24. FUNERAL DIRECTOR NAME <u>Burgee Funeral Home</u>						ADDRESS <u>3631 Falls Road</u>		25a. DATE REC'D BY REGISTRAR <u>JUN 19 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William N. Fields			2a. DATE OF DEATH MONTH DAY YEAR 6-18-79			2b. HOUR 3:24 A M				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 4 04		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1906 N. PULASKI ST.	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Donna Fields						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212 09 2963		17. INFORMANT ADDRESS CHART.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTIC SHOCK. 2050 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) ACUTE MYELOMONOCYTIC LEUKEMIA (c) DUE TO, OR AS A CONSEQUENCE OF 1 YEAR.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDENT.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from MAY 31, 19 79, to June 18, 19 79, that (I) (we) lost saw the deceased alive on June 18, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Jerry I Levine, M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-18-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JERRY I LEVINE						22e. ADDRESS Univ. of Md. Hosp, Balt., Md. 21201				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/22/79		23c. NAME OF CEMETERY OR CREMATORY Garden of Eternal Hope			23d. LOCATION CITY OR TOWN COUNTY STATE Westminister, Md.		
24. FUNERAL DIRECTOR NAME Wm C March F/H						25a. DATE REC'D BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE L. J. Halvord		
25c. ADDRESS 1101 E. North Ave.										

80141

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EUNICE FLORENCE FILES			2a. DATE OF DEATH MONTH DAY YEAR 6/15/79			2b. HOUR MIN. SEC. 11:50 P.M.				
3 SEX Female		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 9 15 05		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY of MD.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retail Sales		12b. KIND OF BUSINESS OR INDUSTRY Stewart Co.		
13a. STATE MARYLAND			13b. COUNTY Bat		13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Bennett E. Ward			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linda Florence			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO 214-24-6089	
17. INFORMANT ADDRESS Eitel M. Files, 1542 Clairidge Rd. 21207										

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Infarct Myocardial Infarction</u> (c) <u>Coronary Artery Insufficiency</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from 6/11/79 to 6/15/79, that (I) (we) last saw the deceased alive on 6/15/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE GARY A. MANKO, MD.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/15/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY A. MANKO, MD.		22e. ADDRESS UNIVERSITY of MARYLAND Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/19/79		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
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24. FUNERAL DIRECTOR NAME Witzke Funeral Home of Catonsville, P.A. 21228		25a. DATE REC'D. BY REGISTRAR JUN 20 1979		25b. REGISTRAR'S SIGNATURE H. H. H. H.	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Item 5 g537 11/8/79 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

14109

REG. NO.

FOR 1. STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Willie	MIDDLE Mae	LAST Finch	2a. DATE OF DEATH		MONTH 6	DAY 21	YEAR 79	2b. HOUR 8	MIN. P
3. SEX Male		4. RACE Black		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City							
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4305 Forest Park Ave.					
14. FATHER'S NAME FIRST Benjamin		MIDDLE Hall		LAST Lula		15. MOTHER'S MAIDEN NAME FIRST Wilson, N.C.		MIDDLE Pinter		LAST St.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-03-6254		17. INFORMANT Otha Finch		ADDRESS 714 Pinter St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarct-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from <u>6-18-79</u> to <u>6-21-79</u> , that (1) (we) lost saw the deceased alive on <u>6-21-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>H. Devadoss</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-21-79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Devadoss		22e. ADDRESS Provident Hospital.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/26/79		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.							
24. FUNERAL DIRECTOR NAME Wm C March F/H		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 26 1979		25b. REGISTRAR'S SIGNATURE <u>Ruby McBrady</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7	9	1	4	1	0		
FOR 1- STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Elizabeth Carolyn Finazzo</i>										2a. DATE OF DEATH MONTH DAY YEAR <i>6 14 79</i>				2b. HOUR <i>8:30 AM</i>			
3 SEX <i>female</i>			4 RACE <i>white</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>11 14 18</i>			6 AGE (IN YEARS LAST BIRTHDAY) <i>60</i>			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY</i> MD.								
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>ST AGNES HOSPITAL</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY <i>Maryland Balto.</i>										13c. CITY OR TOWN <i>Lansdowne</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>2404 Tionesta Road</i>			
14 FATHER'S NAME FIRST MIDDLE LAST <i>William Edward Leisher</i>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Emma Davidson</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. <i>217-09-2922</i>			17 INFORMANT ADDRESS <i>Linda Finazzo same as above</i>											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cor Pulmonale</i> <i>496-</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Chronic Respiratory Failure</i> (c) <i>Chronic Obstructive Pulmonary Disease</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (the hospital) attended the deceased from <i>August</i> 19 <i>75</i> , to <i>6-14</i> 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>6-14</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Joseph H. Miller, MD</i>										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>6-14-79</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>6/16/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ivy Hill Cenetery</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Laurel, Prince Georges, Md</i>									
24 FUNERAL DIRECTOR NAME <i>Raymond C. Fink</i>										ADDRESS <i>Glen Burnie, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 18 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Henry McCurdy</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 1 4 1 1 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES HENRY FISCHBACH SR.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>06 26 79</b>		2b. HOUR <b>2:30 PM</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5/27/13</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SENIOR INSTRUMENT MAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. DEPT. OF AGRICULTURE</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>HENRY FISCHBACH</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LILLIAN SPURRIER</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>220-09-5973</b>		17 INFORMANT ADDRESS <b>MARTHA FISCHBACH, 1639 SPENCE STREET, 21230</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CVA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Nayan Vaywala</b> MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/26/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr Vaywala</b>				22e. ADDRESS <b>ST. AGNES HOSPITAL, 900 CATON AVENUE</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>06-29-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>	
24 FUNERAL DIRECTOR NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 28 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14112

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		June 9, 1979		5 <sup>25</sup> A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Dec. 3, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 67	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KESWICK NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Exec. Secretary		12b. KIND OF BUSINESS OR INDUSTRY Teamsters Uni.	
13a. STATE Maryland		13b. CITY City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Daniel		15. MOTHER'S MAIDEN NAME Rose V. Wright		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 104-28-8219	
17. INFORMANT Stephen W. Fisher,		ADDRESS 1936 Mt. Royal Terrace		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Breast</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (we) (this hospital) attended the deceased from <u>5/7/79</u> 19 <u>79</u> to <u>6/9/79</u> 19 <u>79</u> , that (we) last saw the deceased alive on <u>6/8/79</u> 19 <u>79</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did) (did not) view the body after death.							
22b. SIGNATURE <u>A. Allan Spier, M.D.</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/9/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. ALLAN SPIER		22e. ADDRESS 700 W. 46th St. BALTIMORE MD		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-11-79	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland		24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR JUN 12 1979	
25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>							

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Handwritten notes and signatures on lined paper, including the word "Receipt" and various illegible entries.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William V. Flanigan SR.		2a. DATE OF DEATH MONTH DAY YEAR 6-1-79		2b. HOUR 12 <sup>30</sup> A.M.
3. SEX Male	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR FEB. 3 1909	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.	
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MD. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	12b. KIND OF BUSINESS OR INDUSTRY BALTO. CITY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY BALTO.	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 21209 5739 ROCKSPRING RD.
14. FATHER'S NAME FIRST MIDDLE LAST JOHN A. FLANIGAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE KELLY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-09-1490		17. INFORMANT ADDRESS NELLIE A. FLANIGAN SAME 21209
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Failure 5715 DUE TO, OR AS A CONSEQUENCE OF Cirrhosis of Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 4/10 19 79, to 6/1 19 79, that (I) (we) last saw the deceased alive on 5/30/79 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.				
22b. SIGNATURE Robert Gibson MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/1/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Gibson		22e. ADDRESS U. Md. Hospital Baltimore Md.		
23a. BURIAL, CREMATION, REMOVAL BY BURIAL	23b. DATE 6-4-79	23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEM.	23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME NEWELL F.A. PIRASVILLE MD.		25a. DATE REC'D. BY REGISTRAR JUN 5 1979		25b. REGISTRAR'S SIGNATURE L. J. McElroy





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79 14114	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE F. FLATER, SR.				2a. DATE OF DEATH MONTH DAY YEAR June 23, 1979			2b. HOUR A. 2:10 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 3, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Caton Manor Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Milk			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1211 St. Agnes Lane		
14. FATHER'S NAME FIRST MIDDLE LAST George W. Flater				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Bonnage							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 215-09-6276		17. INFORMANT ADDRESS Carol McDermott, 1221 Newfield Rd. 21207							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Carcinoma of lung &amp; metastases</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 2, 1979</u> to <u>June 23, 1979</u> , that (I) (we) last saw the deceased alive on <u>June 22, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <u>Leon A. Kochman</u> DEGREE _____						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/23/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Leon A. Kochman						22e. ADDRESS 10 Stonehenge Circle, Pikesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/26/79		23c. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville, Carroll, Maryland				
24. FUNERAL DIRECTOR NAME Witzke Funeral Home of Catonsville, 21228						25a. DATE REC'D. BY REGISTRAR JUN 25 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony M. Brady</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

# STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

ISOLATION PRECAUTIONS  
9 PLATE 115

REG. NO.

1. FOR STATE REGISTRAR																			
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					7. HOUR									
EDWARD FLEISCHER					6.14.79					9:32P M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
MALE M			WHITE			11.26.10			68 YRS			MONTHS DAYS		HOURS MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.										
NEW YORK			USA																
10. CITY OR TOWN OF DEATH BALTIMORE					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRESIDENT					12b. KIND OF BUSINESS OR INDUSTRY ADV. AGENCY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
MARYLAND			BALTO.			BALTIMORE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1050 FLAGTREE LA. #21208							
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME														
ALEXANDER FLEISCHER					MARGARET UNKNOWN														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)					17. INFORMANT ADDRESS									
YES					WWII-ARMY					DR. CLARA FLEISCHER 1050 FLAGTREE LA. #2120									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a) Cardio Respiratory Arrest										15 min.									
DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic Encephalopathy										14 days									
DUE TO, OR AS A CONSEQUENCE OF (c) Non A Non B Fulminant Hepatitis										2 wks.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (d) Sepsis, Idiopathic Pulm. Fibrosis.																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (this hospital) attended the deceased from 6.10.1979 to 6.14.1979, that (we) lost saw the deceased alive on 6.14.1979, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Ruth Chacko MD										DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					22c. DATE SIGNED 6.14.79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUTH CHACKO										22e. ADDRESS SINAI HOSPITAL OF BALTIMORE									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION CITY OR TOWN COUNTY STATE				
BURIAL					JUNE 15, 1979					BALTIMORE HEBREW					REISTERSTOWN BALTO. MD				
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215										25a. DATE REC'D. BY REGISTRAR JUN 19 1979					25b. REGISTRAR'S SIGNATURE [Signature]				

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*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

BP

DHMH - 16 25M  
(VR A 15 (4) ) 9/74

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 9 14116			
1. DECEASED NAME (TYPE OR PRINT) <u>BABY GIRL</u> <u>Jamie Ann</u> <u>Fleming</u>				2a. DATE OF DEATH MONTH <u>6</u> DAY <u>29</u> YEAR <u>79</u>			
3 SEX <u>Female</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH <u>6</u> DAY <u>29</u> YEAR <u>79</u>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS <u>8</u> DAYS <u>8</u> MIN. <u>8</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>U.S.A.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE CITY</u> MD.	
10. CITY OR TOWN OF DEATH <u>BALTIMORE</u>		11. NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>UNIVERSITY of Maryland</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>—</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
13a. STATE <u>Md.</u> 13b. COUNTY <u>Dorchester</u> 13c. CITY OR TOWN <u>Dorchester</u>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <u>Dorchester Gen'l Hospital</u>			
14. FATHER'S NAME FIRST <u>G.C. CLAYTON</u> MIDDLE <u>—</u> LAST <u>FLEMING</u>				15. MOTHER'S MAIDEN NAME FIRST <u>CYNTHIA</u> MIDDLE <u>Ann</u> LAST <u>Marshall</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT ADDRESS <u>Mrs. Fleming, RFD 2, Cambridge, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>7689</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Respiratory Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Prematurity and Birth Asphyxia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 hours since birth</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3 AM 6-29</u> , 19 <u>79</u> , to <u>4:15 AM 6-29</u> , 19 <u>79</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>6-29</u> , 19 <u>79</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> did (did not) view the body after death.							
22b. SIGNATURE <u>Saralyn S. Vogel MD</u> DEGREE <u>Resident</u>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/29/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SARALYN S. VOGEL MD</u>				22e. ADDRESS <u>University of Maryland Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		23b. DATE <u>July 2, 1979</u>		23c. NAME OF CEMETERY OR CREMATION <u>Scotts Chapel Church</u>		23d. LOCATION CITY OR TOWN <u>Bucktown</u> COUNTY <u>Dorchester</u> STATE <u>Md.</u>	
24. FUNERAL DIRECTOR <u>Curran Funeral Home, 308 High St.</u>				25a. DATE <u>JUL 6 1979</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Delores E. Flowers</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6 27 79</i>		2b. HOUR <i>11:30 AM</i>
3. SEX <i>F</i>	4. RACE <i>Neg</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>13 4 32</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>47</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>BALT</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. <u>BALTIMORE CITY OR COUNTY OF DEATH</u> MD	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sinai Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>MD</i>		13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>6202 Bonnie Ridge Rd.</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Moses Chinn</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Beatrice Ford</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>	
16b. SOCIAL SECURITY NO. <i>212-32-6246</i>		17. INFORMANT ADDRESS <i>Eugene Flowers 55 Strawhat Rd.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sub Arachnoid Hemorrhage</i> <i>4275</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <i>Cerebral Arteriosclerosis</i> (c) <i>Arteriosclerosis</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Frank W. Braxton</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>27 June 79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Frank W. Braxton</i>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6/30/79</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Pk.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Arbutus, Md.</i>
24. FUNERAL DIRECTOR NAME <i>Wm C. March F/H</i>		ADDRESS <i>1101 E. North Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 29 1979</i>	25b. REGISTRAR'S SIGNATURE <i>Robert M. Brady</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VRA 15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14118

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH F. FLOWERS</b>				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>6 13 1979</b>		2b. HOUR <b>3:23</b>	
3. SEX <b>male</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 2 14</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>64 YRS.</b>	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD <b>6 13 1979</b>	2d. HOUR <b>A M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>528 E. 20th Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harrison Flowers</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Caroline Liles</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WWII</b>			
17. SOCIAL SECURITY NO. <b>219-07-4412</b>		18. INFORMANT ADDRESS <b>Mearlener F. Johnson 619 Cecil St</b>					
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>		TITLE (SPECIFY) <b>Assistant</b>		MEDICAL EXAMINER		DATE SIGNED <b>6/13/79</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>		ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/15/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Co., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>		ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Pearl M. FLOWERS					June 11 1979				7:05A M
3 SEX	4 RACE	5 DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	MONTH DAY YEAR 07 07 22			56 YRS.		MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND	U.S.A.				Baltimore City MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore	Maryland General Hospital			MEAT PACKER		MEAT			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS				
MARYLAND			BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	PACKING 1206 W. 36th ST., 21213				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					
FIRST MIDDLE LAST MELVIN LEE WALTER SR.		FIRST MIDDLE LAST MARGARET TRIP		16b. SOCIAL SECURITY NO. 215-12-3871					
				17. INFORMANT ADDRESS RAYMOND A. WALTER, 238 ALLWOOD DRIVE FERNDAL, MD.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <u>High Blood Pressure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adult Onset Diabetes Mellitus</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 29</u> , 19 <u>79</u> to <u>June 11</u> , 19 <u>79</u> , that <input checked="" type="checkbox"/> saw the deceased alive on <u>June 11</u> , 19 <u>79</u> , and that in <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.		22b. SIGNATURE <u>Judy Stone, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-11-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Judy Stone, M.D.		c/o Maryland General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		STATE	
BURIAL		06-14-79		FORK METHODIST		FORK		BALTIMORE MD.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HUBBARD FUNERAL HOME, INC.,		4107 WILKENS AVE.		21229 JUN 13 1979		<u>Petry Melvody</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



U.S. Atomic Energy

Refined General Analysis

original

Multiple Choice Questions

222

c/o Marjorie General Hospital

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

14120

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CLARENCE EVERHARDT FOARD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 7/79</b>			2b. HOUR <b>2:36 PM</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 14, 1899</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Milk Man</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Knootz</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a STATE <b>Maryland</b>		13b COUNTY		13c CITY OR TOWN <b>Baltimore</b>		13e. STREET ADDRESS <b>2812 Bayonne Ave. 21214</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Aaron Foard</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine White</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO. <b>215-10-3852</b>		17 INFORMANT ADDRESS <b>Mrs. Augusta A. Foard Same</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/7</b> , 19 <b>79</b> , to <b>6/7</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/7</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>lynare MD</b>						DEGREE		22c. DATE SIGNED <b>6/7/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>YNARES</b>						22e. ADDRESS <b>GOOD SAMARITAN HOSP</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>June 11, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc. Balto, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Harry McBrady</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMM-16 20M  
(VRS 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 4 1 2 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>FREDERICK John Fontz</b>				2a. DATE OF DEATH MONTH <b>6</b> DAY <b>20</b> YEAR <b>79</b>		2b. HOUR <b>05</b> PM	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>July</b> DAY <b>5</b> YEAR <b>1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Deaton Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter (ret)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Mathison Chem</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Wilbur</b> MIDDLE <b>Fontz</b> LAST <b>Fontz</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Josephine</b> MIDDLE <b>Conway</b> LAST <b>Conway</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>215109341A</b>		17. INFORMANT (wife) <b>Mrs. Elizabeth V. Fontz</b>		17. ADDRESS <b>Same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>7070</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Appt</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Appt de cerebral vessels.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5-31</b> , 19 <b>79</b> , to <b>6-20</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6-20</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b> DEGREE <b>[Signature]</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/21/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. Brown</b>		22e. ADDRESS <b>611 D. Charles St</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 23, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn A.A. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>R. H. Hopkins</b> ADDRESS <b>Singleton Funeral Home, Glen Burnie, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1607 BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 9 1 4 1 2 2 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)		FIRST ASSLIE		MIDDLE		LAST FOOT		2a. DATE OF DEATH MONTH DAY YEAR 6 7 79		2b. HOUR 8:43a M
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 - 4 - 06		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.				
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3246 Westmont Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3246 Westmont Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Mayfield		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hassie Thompson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 261-53-9782		17. INFORMANT ADDRESS Ruth Moffett 3246 Westmont St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA with left hemiparesis + dysarthria 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF: (b) Diabetes Mellitus (adult onset) DUE TO, OR AS A CONSEQUENCE OF: (c) Hypertensive arteriosclerotic cardiovascular disease - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH incl 1-9-79										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Severe Chronic Brain Syndrome due to diffuse cerebral atrophy										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from Jan 31, 1979 to May 21, 1979, that (I) (we) last saw the deceased alive on May 21, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Corazon M. Cuevas, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CORAZON M. CUEVAS, M.D.		22e. ADDRESS 2201 Argonne Dr., Balt., Md. 21218								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/12/79		23c. NAME OF CEMETERY OR CREMATORY King Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co., Md.				
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 12 1979		25b. REGISTRAR'S SIGNATURE Lillian McCreedy		



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 1 2 3

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ELLA Mae FORD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 4, 1979</b>		2b. HOUR <b>9:30A</b>		
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6-10-1933</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>45</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Maryland Chas Bryantown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 5 - Box 9</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Borenza Washington</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes Young</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>214-30-2262</b>		17. INFORMANT ADDRESS <b>Joann M. Ford SAA</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cachexia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cervical Cancer Probably Recurrent</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from <b>MAY 7, 1979</b> to <b>JUNE 4, 1979</b> , that (b) (I) (we) lost saw the deceased alive on <b>JUNE 4, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)							

MEDICAL CERTIFICATION

17a. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

6-4-79

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

RAFAEL WACISKI MD

JOHNS HOPKINS HOSP. BALTIMORE

23a. BURIAL CREMATION, REMOVAL

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Burial

6/7/79

St. Peters Ch. Co.

Waldorf

Chas

MD

24. FUNERAL DIRECTOR

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Martell Adams - Aquasco, Md.

JUN 11 1979

Rafael Waciski

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, pages 1 and 2 should be detached for use as the required form for burial. Then please remove section papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other medical condition, a medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M/7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>EDNA BELL FORNEY</b>			2a. DATE OF DEATH MONTH <b>6</b> DAY <b>26</b> YEAR <b>79</b>			2b. HOUR <b>7<sup>25</sup> P.M.</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>18</b> YEAR <b>04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kansas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MONTABELLO CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b></b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST <b>John W.</b> MIDDLE <b>McGinnis</b> LAST <b></b>			15. MOTHER'S MAIDEN NAME FIRST <b>Sarah</b> MIDDLE <b>Haas</b> LAST <b></b>			13e. STREET ADDRESS <b>802 Overbrook Rd.</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>270-05-0783</b>		17. INFORMANT <b>Mr. Kenneth D. Forney</b>				ADDRESS <b>Same</b>	

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 MINS.</b>	
2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) <b>DIABETES MELLITUS</b>	
		(c) <b>10 YEARS.</b>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>DECUBITUS ULCERS</b>			
19a. DATE OF OPERATION <b>2/8/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b></b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b></b>		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <b></b>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE: <b></b>	
22a. I certify that (this hospital) attended the deceased from <b>2/8/79</b> , 19 <b>79</b> , to <b>6/26</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/26</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Shahid Saeed</b>		DEGREE <b>MD</b>	
22c. DATE SIGNED <b>6.26.79</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SHAHID SAEED</b>		22e. ADDRESS <b>199 LIONHEAD COURT, BART, MD 21237</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 30, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Govans Presbyterian</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc.</b>		ADDRESS <b>Baltimore, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>P. J. McCready</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, it should be detached for use as the burial-transit permit. Then please remove to the proper authorities. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 7 9 1 4 1 2 5 REG. NO.										
1- FOR STATE REGISTRAR (Lashawn)										
1 DECEASED NAME (TYPE OR PRINT) Baby Girl Forrest					2a. DATE OF DEATH MONTH DAY YEAR June 19, 1979			2b. HOUR 9:23pm		
3. SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 15 79		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 4		7 UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Johns Hopkins Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.					13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST David Forrest					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Branch					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17 INFORMANT David Forrest		ADDRESS 4105 Eastmont Ave.				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Arrest</u> 7469 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metabolic Abnormalities and hypoxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congenital Heart Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Neurology Enterocolitis</u>										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>6/16</u> , 19 <u>79</u> , to <u>6/19</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/19</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Sharon Shinn</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>6/19/79</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sharon Shinn		22e. ADDRESS Johns Hopkins Hospital								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/21/79		23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.				
24. FUNERAL DIRECTOR NAME Wm. C. March F/H, Inc.		ADDRESS 1101 E. North Ave		25a. DATE REC'D. BY REGISTRAR JUN 22 1979		25b. REGISTRAR'S SIGNATURE <u>Lashawn</u>				

ISSN 0013-788X

Item 8 8532 6/19/79 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

1 4 1 2 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM HENRY FORSTNER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 4 79</b>			2b. HOUR <b>3:40 AM</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 27 1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>48 88</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>WISCONSIN</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAME AND SUCH FACILITY, GIVE STREET ADDRESS) <b>VETERANS ADMINISTRATION MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Storekeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>A.A.Co.</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7623 Turnbrook Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph ----- Forstner</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kathryn ----- Sauer</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WW I</b>		17. INFORMANT ADDRESS <b>VAMC, CLINIC RECORDS Baltimore, Md. 21218</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Brain Tumor</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION <b>4/16</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Brain Tumor</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 1, 1979</b> to <b>JUNE 4, 1979</b> , that (I) (we) last saw the deceased alive on <b>JUNE 4, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.									
22b. SIGNATURE <b>Sylvain Palmer, M.D.</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sylvain Palmer, M.D.</b>				22e. ADDRESS <b>3900 Loch Raven Blvd. Balto., Md. 21218</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 7, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>McClully Funeral Home, 130 E. Fort Ave. Balto. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Littray Helms</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MAILED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 4 1 2 7		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Betty Doris Fowler				2a. DATE OF DEATH MONTH DAY YEAR June 5, 1979		2b. HOUR 11:45 <sub>M</sub> P			
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Dec. 3, 1929		6 AGE (IN YEARS LAST BIRTHDAY) 49 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Davidson Chemical		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. CITY OR TOWN AA Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 47 Chester Circle			
14 FATHER'S NAME FIRST MIDDLE LAST Lonnie C. Meade				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Cantrell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS Byron Fowler, Husband, Same as 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary arrest - 5750 DUE TO, OR AS A CONSEQUENCE OF (b) Septicemia, Gangrenous G. Bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 6.4.79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrenous Cholecystitis				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5-20, 1979, to 6.5, 1979, that (I) (we) last saw the deceased alive on 6.5, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ahmad				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 6.5.79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MIRZA M. AHMAD				22e. ADDRESS ST AGNES HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9 June 79		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA, Md.			
24 FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, Md.				25a. DATE REC'D. BY REGISTRAR JUN 8 1979		25b. REGISTRAR'S SIGNATURE Rickey McCreedy			

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OF



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 1 2 8

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Sarah ELIZABETH FRANCIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 12, 1979</b>		2b. HOUR <b>3:02A</b>
3. SEX <b>Female</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 10 10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balto.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Balto.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Griffin</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Little</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-22-7741</b>		17. INFORMANT ADDRESS <b>Theodore Francis 2717 Spellman Rd.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOpulmonary arrest</b> <b>4254</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>congestive heart failure And renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ischemic Cardiomyopathy</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6/11</b> , 19 <b>79</b> , to <b>6/12</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/12/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Carla Janison M.D.</b>		DEGREE		22c. DATE SIGNED <b>6/12/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CARLA JANISON M.D.</b>		22e. ADDRESS <b>Johns Hopkins Hosp.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>6/16/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Co., Md.</b>
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>		ADDRESS <b>1101 E. North Ave.</b>	
25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The Registrar requires that the death certificate be retained by the hospital or attending physician for 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copies and forward them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3 5 1 4 1 0 8

1. All entries on  
this form must be  
made in ink.



RECEIVED  
JUN 10 1953  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.

UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250  
OFFICE OF THE SECRETARY  
ATTENTION: Mr. [Name]  
MAIL ROOM  
JUN 10 1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 14129	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST
JOSEPH P. FRANK					
3. SEX		4. RACE		5. DATE OF BIRTH	
male		W		MONTH DAY YEAR 09 16 1900	
6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
78 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
HUNGARY		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
BALTIMORE		Bow & Courie Hospital		SHOEMAKER	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY	
		MARYLAND		BALTIMORE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13c. CITY OR TOWN	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		BALTIMORE	
HENRY		UNKNOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
NO		212-07-6326		JAMES SHEHAN, 2031 CLIFTON AVENUE, 21216	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Hepatic Failure</u> 5728 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/5</u> 19 <u>79</u> , to <u>6/4</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/5</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Helen M. Sabunsky</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/5/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROSENA M. SABUNSKY		22e. ADDRESS Bow & Courie Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		06-08-79		MT. OLIVET CEMETERY	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.		21229		JUN 6 1979	
25b. REGISTRAR'S SIGNATURE <u>Esther Sabunsky</u>		25c. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND			

21418

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 1 4 1 3 0			
1 - FOR STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
Franklin James			Franklin						6 21 79			9 29 A M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
male		Black		9 28 08			70			YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland			USA						Balt City MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Balt			University Maryland Hospital										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
Md			Calvert		Dunkirk				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2264 Boyd St. Howard Rd. 21223		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Charlie Franklin			Louise Watkins Franklin										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS							
no			579-38-7239			Otha Franklin Box 402 Dunkirk, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>										24 h.			
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute anterior lateral myocardial infarction</u>													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
Coronary Artery Disease													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
			P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from <u>6/20</u> , 19 <u>79</u> , to <u>6/21</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/21</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.													
22b. SIGNATURE			DEGREE						22c. DATE SIGNED				
<u>Ronald J. Ross MD</u>									6/21/79.				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
R. Ronald J. Ross MD			Univ Md Hosp										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN		COUNTY STATE			
Burial			June 25-79		Coopers Chr. Cem.			Dunkirk		Calvert Md.			
24. FUNERAL DIRECTOR NAME						ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Spencer E. Sewell						Prince Frederick, Md.		JUN 27 1979		<u>Ronald J. Ross</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ETHEL</b>			FIRST <b>H.</b> MIDDLE <b>FRAZIER</b> LAST			2a. DATE OF DEATH MONTH <b>6</b> DAY <b>10</b> YEAR <b>79</b>			2b. HOUR <b>10:55</b> M				
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>21</b> YEAR <b>02</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13b. STREET ADDRESS <b>4430 Parkton St. 21229</b>				
13a. STATE <b>Md.</b>			13b. COUNTY			13c. CITY OR TOWN <b>Baltimore</b>			14. FATHER'S NAME FIRST <b>Brackenridge</b> MIDDLE <b></b> LAST <b>Hayes</b>				
15. MOTHER'S MAIDEN NAME FIRST <b>Jemima</b> MIDDLE <b></b> LAST <b>Davis</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. <b>403-05-1491</b>			17. INFORMANT ADDRESS <b>Mr. Paul B. Frazier (as above)</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPSIS</b> <b>5990</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RECURRENT URINARY TRACT INFECT.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CONGESTIVE HEART FAILURE</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19 79</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>June 6</b> , 19 <b>79</b> , to <b>June 10</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>June 10</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>C. D. M.</b>						DEGREE			22c. DATE SIGNED <b>6/10/79</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. CATHERINE D'ARCANQUES</b>						22e. ADDRESS <b>900 SO. CATON AVE. BALTO. MD. 21229</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/13/1979</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>G. Tryman Schwab</b> ADDRESS <b>3512 Frederick Ave.</b>						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <b>Henry A. Brady</b>				

JUN 18 1979



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 4 1 3 2 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <u>Peter J. Frederick (Frydrych - Fridrych)</u>						2a. DATE OF DEATH MONTH DAY YEAR <u>June 11, 1979</u>		2b. HOUR <u>10:00 AM</u>	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>June 22, 1882</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>96</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <u>Poland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.			
10. CITY OR TOWN OF DEATH <u>Balto. Md.</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>House in the Pines - Belair</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Stevedore</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <u>Md.</u>		13b. COUNTY <u>Balto.</u>		13c. CITY OR TOWN <u>Balto.</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Unknown</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Unknown</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>215-09-3919</u>		17. INFORMANT ADDRESS <u>Mrs. Stella Butka - 6503 Kenwood Ave. - 21237</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>410-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Organic brain syndrome.</u>									
19a. DATE OF OPERATION <u>6/11/79</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Organic brain syndrome.</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <u>79</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u>4/11/79</u>					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>8604 Harford Rd. Balto. Md.</u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>2-1</u> 19 <u>79</u> , to <u>6/11/79</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5/21</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Marion C. Kowalewski</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>6/12/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>8604 Harford Rd</u>				22e. ADDRESS <u>M. KOWALEWSKI MD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>6-14-79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto. Md.</u>			
24. FUNERAL DIRECTOR NAME ADDRESS <u>John C. Miller Inc-6415 Belair Rd.-21206</u>						25a. DATE REC'D. BY REGISTRAR <u>JUN 13 1979</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MORRIS FRIEDMAN</b>			2a. DATE OF DEATH MONTH <b>06</b> DAY <b>24</b> YEAR <b>79</b>		2b. HOUR <b>4:40 P.M.</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>04</b> DAY <b>05</b> YEAR <b>1903</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TRAIN INVESTIGATOR B&amp;O RAILROAD</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>#21215</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MD</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b> <del>XXXX</del> NO <b>X</b>	13e. STREET ADDRESS <b>5523 Nome Avenue</b>		
14. FATHER'S NAME FIRST <b>ISAAC</b> MIDDLE <b>FRIEDMAN</b> LAST <b>FRIEDMAN</b>		15. MOTHER'S MAIDEN NAME FIRST <b>IDA</b> MIDDLE <b>ROSENTHAL</b> LAST <b>ROSENTHAL</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. <b>705-09-1474</b>	17. INFORMANT <b>MRS. ANNA FRIEDMAN</b> <b>5523 NOME AVE. #21215</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b>4</b> A.M. MONTH <b>06</b> DAY <b>24</b> YEAR <b>1979</b> <b>P.M.</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>CARDIOGENIC SHOCK</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>06/10</b> , 19 <b>78</b> , to <b>06/24</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>06/24</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>EJAL Bogin MD</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>06/24/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EJAL Bogin</b>			22e. ADDRESS <b>40 SINAI HOSPITAL</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>JUNE 26, 1979</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CHIZUK AMUNO (ARLINGTON)</b>	23d. LOCATION CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 27 1979</b>	25b. REGISTRAR'S SIGNATURE <b>Anthony McBrody</b>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH PAGE 3, RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14134

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST ROBERT			MIDDLE JOHN			LAST FREEMAN			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH 5			DAY 28			YEAR 79			2b. HOUR 12:20 P		
3. SEX male			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR 12-12-1976			6. AGE (IN YEARS) LAST BIRTHDAY 2 YRS.			IF UNDER 1 YR. MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.			7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 28 79			2d. TIME					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ind.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED WIDOWED			NEVER MARRIED			DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD											
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) non-child			12b. KIND OF BUSINESS OR INDUSTRY			13a. INSIDE CITY LIMITS? YES NO			13b. STREET ADDRESS Rt 1, Box 348 F			13c. CITY Berkley Springs			13d. STATE W. Va.					
14. FATHER'S NAME FIRST MIDDLE LAST Lloyd Clark Freeman Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deborah Kay Neal			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. -			17. INFORMANT John Thomas Neal			17b. ADDRESS (Some).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epiglottitis 4643 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																										
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																										
ACTUAL SIGNATURE Margarita A. Korell						TITLE (SPECIFY) Assistant						DATE 5/29/79														
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.						ADDRESS 111 Penn Street																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 6-1-1979						23c. NAME OF CEMETERY OR CREMATORY Green Home Trm. Pk.						23d. LOCATION CITY OR TOWN COUNTY STATE Green Home Trm. Pk. Ind.								
24. FUNERAL DIRECTOR NAME John J. Cronan						ADDRESS S. W. 90, Hallsville						25a. DATE REC'D. BY REGISTRAR MAY 31 1979						25b. REGISTRAR'S SIGNATURE Dorothy McCreedy								

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Charlotte May Friend</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 17, 1979</b>			2b. HOUR <b>2:07 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug 25 1881</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Caton Manor Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AT HOME</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5819 BENSON HIGGS AVE 21206</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Aved</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA M HENKINS</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-54-3326</b>		17. INFORMANT ADDRESS <b>Mrs. Melba J. Jule, 5819 BENSON HIGGS AVE.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypertension</b> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Primary cardiac</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arterio Sclerotic Cardio Vaso. Dis.</b> 10 yrs								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 1, 1972</b> to <b>June 17, 1979</b> , that (we) (I) saw the deceased alive on <b>6/15</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (we) (we) (did not) view the body after death.									
22b. SIGNATURE <b>J. Nelson McKay</b>			DEGREE <b>R.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>June 18, 1979</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Nelson McKay</b>			22e. ADDRESS <b>1132 N. Rolling Road Balt., Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIAL) <b>BORIAL</b>			23b. DATE <b>20 June 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WOOD LAWN CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD.</b>		
24. FUNERAL DIRECTOR NAME <b>Ullrich Funeral Home</b>			ADDRESS <b>Baltimore, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>11 JUN 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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M

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 1 3 6

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <div style="display: flex; justify-content: space-between;"><span>Edward</span><span>J.</span><span>Fritz</span></div>			2a DATE OF DEATH MONTH DAY YEAR <div style="display: flex; justify-content: space-between;"><span>June 3,</span><span>1979</span></div>		2b HOUR 3:54 <sup>MP</sup>	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR <div style="display: flex; justify-content: space-between;"><span>04</span><span>16</span><span>01</span></div>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		12b KIND OF BUSINESS OR INDUSTRY Electrical Instructor BG&E		13b STREET ADDRESS 5517 Link Ave. 21227		
14 FATHER'S NAME FIRST MIDDLE LAST Frederick Fritz		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Zimmerman		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		
16b SOCIAL SECURITY NO. 212-05-4794		17. INFORMANT Harry Fritz		ADDRESS 5509 Link Avenue		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion acute</u> <u>2500</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>undet.</u> <u>2 yrs</u>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (the hospital) attended the deceased from <u>April 7</u> , 19 <u>77</u> , to <u>June 3</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>June 3</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <u>A. Bradley Daugharthy</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/3/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. Bradley Daugharthy		22e. ADDRESS 1264 Francis Avenue 21227				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 6, 1979		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		25a. DATE REC'D. BY REGISTRAR JUN 5 1979				
24 FUNERAL DIRECTOR NAME Ambrose Funeral Home, Inc. 1328 S. Sprng Rd.		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Received 12 October 2004; accepted 12 November 2004

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BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14137

1. DECEASED NAME (TYPE OR PRINT)		FIRST ARTHUR		MIDDLE Robert		LAST FROST		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH 6		DAY 4		YEAR 1979		2b. HOUR M					
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 11-17-15		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD		MONTH 6		DAY 4		YEAR 1979		2d. HOUR P M 1:20			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.											
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor				12b. KIND OF BUSINESS OR INDUSTRY Laundry							
13a. STATE Maryland				13b. COUNTY Baltimore				13c. CITY OR TOWN Parkville				13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 6921 Donachie Rd 21239							
14. FATHER'S NAME FIRST MIDDLE LAST Edward Morris Frost Sr.								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret O'Dwyer															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes WWII				16b. SOCIAL SECURITY NO. 216-03-3729				17. INFORMANT ADDRESS Rosalie L. Frost 6921 Donachie Rd. 21239															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. Diabetes mellitus																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				M.D. Assistant MEDICAL EXAMINER								DATE SIGNED 6-5-79											
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6-8-79				23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore ----- Md.											
24. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home 6500 York Rd. 21212										25a. DATE REC'D. BY REGISTRAR JUN 11 1979				25b. REGISTRAR'S SIGNATURE L. H. McCreedy									



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Items #10a-22a Film G533 7/12/79 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
1- FOR STATE REGISTRAR  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14138

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR		
Beatrice Ann Frost						X			6 6 1979			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR		
female	black	4 23 53	26 YRS.			6 6 1979			11:55 p.			M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.			USA						Baltimore City MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			Provident Hospital											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Md.						Balto.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3803 Belle Ave.		
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST						FIRST MIDDLE LAST								
Ambrose Frost						Helen Vanlandingham								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No						214-54-9490			Helen White			3803 Belle Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Chronic alcoholism with fatty infiltration of the liver														
5710 DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														
(b) DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?		
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
				HOUR A.M. MONTH DAY YEAR										
				P.M. 19										
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED						
Virginia L. Dolan				Assistant				6/7/79						
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS										
Virginia L. Dolan, M.D.				111 Penn Street, Balto., MD 21201										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				
Burial				6/11/79		Mt. Calvary Cem.				Anne Arundel Co., Md.				
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
Wm C March F/H						1101 E. North Ave.				JUN 11 1979				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



U. G. I. P. I. 9. A.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14139

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Alvin			MIDDLE R.			LAST Fullard 3rd			2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 7 19 79			2b. HOUR M a				
3. SEX male		4. RACE negro		5. DATE OF BIRTH MONTH DAY YEAR 3 18 61		6. AGE (IN YEARS LAST BIRTHDAY) 18 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 7 19 79			7d. HOUR M a				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) rear 2012 N. Charles St.								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.				13b. COUNTY				13c. CITY OR TOWN Balto.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 2701 The Alameda			
14. FATHER'S NAME FIRST MIDDLE LAST Alvin R. Fullard, Sr.								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Stukes											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS Maggie Fullard 2701 The Alameda											

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wounds of head and chest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:30 PM 6-7-19 79				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Shot by assailant.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) alley				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2012 N. Charles St. Balto. Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 6-7-79	
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/13/79				23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.				23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md.	
24. FUNERAL DIRECTOR NAME Wm C March F. H.				ADDRESS 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR JUN 8 1979					

1347

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14140

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HATTIE F. FUXMAN</b>			2a. DATE OF DEATH MONTH <b>6</b> DAY <b>29</b> YEAR <b>79</b>			2b. HOUR <b>4:54p</b> M.					
3. SEX <b>F</b> FEMALE		4. RACE <b>C</b> CAUCASIAN		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>31</b> YEAR <b>1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS		IF UNDER 1 YEAR MONTHS <b>8</b> DAYS <b>24</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LEGAL SEC.</b>		12b. STATE OF BUSINESS OR INDUSTRY <b>ATTY. GEN.</b>					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>APT. D-7 #21215</b>	
14. FATHER'S NAME FIRST <b>JACOB</b> MIDDLE <b>FUXMAN</b> LAST <b>BERMAN</b>				15. MOTHER'S MAIDEN NAME FIRST <b>REBECCA</b> MIDDLE <b>BERMAN</b> LAST <b>BERMAN</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>220-36-9672</b>				17. INFORMANT <b>HENRY FOXMAN</b> ADDRESS <b>117 ROCKRIMMON RD., REISTERSTOWN, MD 21136</b>				18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOGENIC SHOCK</b> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF 1b. <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF 1c. <b>CA LUNG C BRAIN METASTASES</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b> <b>24 HOURS</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CA LUNG C BRAIN METASTASES</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR <b>A.M.</b> MONTH <b>6</b> DAY <b>29</b> YEAR <b>1979</b> P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET <b>SINAI HOSPITAL</b> CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE <b>MD</b>			
22a. I certify that (1) this hospital attended the deceased from <b>6/22</b> 19 <b>79</b> to <b>6/29</b> 19 <b>79</b> , that (2) (we) last saw the deceased alive on <b>6/29</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (3) we did not give aid by attending death.											
22b. SIGNATURE <b>William S. Wood</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>6/29/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM S WOOD MD</b>				22e. ADDRESS <b>SINAI HOSPITAL</b>				23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			
23b. DATE <b>JULY 2, 1979</b>				23c. NAME OF CEMETERY OR CREMATORY <b>MIKRO KODESH BETH ISRAEL</b>				23d. LOCATION CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE <b>MD</b>			
24. FUNERAL DIRECTOR <b>SOL LE VINSON &amp; BROS., INC.</b> NAME <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b> ADDRESS						25a. DATE REC'D. BY REGISTRAR <b>JUL 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>			

0 0 1 5 1 0 0 0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 1 4 1 4 1 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Russell M. Fye</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>June 26, 1979</b>				2b. HOUR <b>8:00p</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 4 28</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS <b>51</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Crane Oper.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Klauff Const.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>238 S. Wolfe Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
<b>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes Korean</b></b>				16b. SOCIAL SECURITY NO. <b>723-18-2762</b>		17. INFORMANT <b>Shirley M. Fye</b>		ADDRESS: <b>238 S. Wolfe St. Balto. MD 21231</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxic Encephalopathy</b> 486- DUE TO, OR AS A CONSEQUENCE OF (b) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumonia / COPD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b> <b>9 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/17</b> , 19 <b>79</b> , to <b>6/26</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/26</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Lawrence S. Friedman MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>6/26/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LAWRENCE S. FRIEDMAN</b>				22e. ADDRESS <b>Johns Hopkins Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/30/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Mem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>White Marsh, Balto. MD</b>	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>	

BP

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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15M 7/76

FOR  
1- STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14142  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Norman			MIDDLE Frederick			LAST Gabriel			2b. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 17 19 79			2d. HOUR 9:58P				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 28, 1954 25 YRS.			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS HOURS MIN			7c. DATE PRONOUNCED DEAD 6 17 19 79			2d. HOUR 9:58P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.							
10. CITY OR TOWN OF DEATH Baltimore City				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Food Service Mgr.				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Md.				13b. COUNTY AA				13c. CITY OR TOWN Glen Burnie				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 435 Hardmoore Court			
14. FATHER'S NAME FIRST MIDDLE LAST Norman Gabriel						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Yelmans													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 091-46-9172				17. INFORMANT Wife, Kathleen Gabriel, same as 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8152 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN MONTH DAY YEAR 7:53 P.M. 6 17 19 79				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in motorcycle/fixed object impact											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Jumpers Hole Rd. A.A. MD											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 6/18/79					
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn St. Balto., MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 20 June 79				23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem.				23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA MD.							
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, Md.										25a. DATE REC'D. BY REGISTRAR JUN 20 1979				25b. REGISTRAR'S SIGNATURE Anthony McCreedy					

14142



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How you

Good service

Good service

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Good service

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 7 9 1 4 1 4 3						
1. DECEASED NAME (TYPE OR PRINT) <b>EDITH Pauline GAGEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 24 79</b>			2b. HOUR <b>9 50 AM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 7, 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Rental Agent</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Apts.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>Lorena Avenue 21230</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carl Money Penny</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie G. Griffith</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>235 12 2520</b>		17. INFORMANT ADDRESS <b>Wilma Buggenhagen 2 Sunset Circle Pasadena, Md. 21122</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b> <b>1539</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Ca of colon</b> (c) <b>Dys</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8'</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>6/22</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Recurrent colon Ca</b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>6/14 19 79 to 6/24 19 79</b>					
22. I certify that (I) (this hospital) attended the deceased from <b>6/14 19 79</b> to <b>6/24 19 79</b> , that (I) (we) last saw the deceased alive on <b>6/24 19 79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
27a. SIGNATURE <b>Ronald J. Kendig</b>				DEGREE <b>MD</b>				27c. DATE SIGNED <b>6/24/79</b>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RONALD J. KENDIG</b>				27b. ADDRESS <b>UNION MEMORIAL HOSP.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 28, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pl.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>McCurly Funeral Home</b>				24b. ADDRESS <b>337 East Patapsco Avenue Baltimore, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Timothy McCreedy</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST ROBERT M. GAMBLE		MONTH DAY YEAR 6 23 79	
3. SEX F		2b. HOUR 11:30AM	
4. RACE WHITE		5. AGE (IN YEARS LAST BIRTHDAY)	
5. DATE OF BIRTH MONTH DAY YEAR APRIL 28 1928		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) VICE PRESIDENT		12b. KIND OF BUSINESS OR INDUSTRY INSURANCE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. CITY OR TOWN BALTO.	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT GAMBLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE SMITH	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO.		16b. SOCIAL SECURITY NO. 213-28-5843	
17. INFORMANT ADDRESS ROBERTA GROPPER 15300 BEAUFORT PLACE SILVER SPRING			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS 1749 DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA JAUNDICE DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC BREAST CA.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (this hospital) attended the deceased from 6-23, 19 79, to 6-23, 19 79, that (we) last saw the deceased alive on 6-23, 19 79, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.			
22b. SIGNATURE Dennis J. Chodnicki		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DENNIS J. CHODNICKI		22e. ADDRESS 201 E. UNIVERSITY PARKWAY BALTO, MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-26-79	
23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE PARK		23d. LOCATION CITY OR TOWN COUNTY STATE HOWARD CO. MD.	
24. FUNERAL DIRECTOR NAME FARLEY F.H.		25a. DATE REC'D. BY REGISTRAR JUN 28 1979	
ADDRESS 6601 FRED. AVE.		25b. REGISTRAR'S SIGNATURE Anthony McCreedy	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR				7 9 1 4 1 4 5 REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) <b>CEPHAS GANTT</b>				2a DATE OF DEATH MONTH <b>6</b> DAY <b>22</b> YEAR <b>79</b>				2b HOUR <b>4:05A</b> M	
3 SEX <b>MALE</b>		4 RACE <b>BLACK</b>		5 DATE OF BIRTH MONTH <b>1</b> DAY <b>6</b> YEAR <b>24</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		7 IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CALVERT CO.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE, CITY</b> MD.			
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC, LOCH RAVEN BLVD., BALTO. MD.</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Labor</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>MARYLAND</b>		13b COUNTY <b>Calvert</b>		13c CITY OR TOWN <b>Pr. Frederick</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME FIRST <b>Alexander</b> MIDDLE <b></b> LAST <b>Gantt</b>				15 MOTHER'S MAIDEN NAME FIRST <b>Rosa</b> MIDDLE <b></b> LAST <b>Johnson</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17 INFORMANT ADDRESS <b>Helen M. Gantt Box 399 Pr. Frederick, Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Esophageal Cancer</b> <b>1509</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b></b> (c) <b></b> DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET <b>3900 LOCH RAVEN BLVD.</b> CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b> STATE <b>21218</b>					
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>5-18</b> , 19 <b>79</b> , to <b>6-22</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>6-22</b> , 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we did not know the body after death).									
22b SIGNATURE <b>R. Phillips MD</b>				DEGREE <b></b>				22c DATE SIGNED <b>6-22-79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. PHILLIPS</b>				22e ADDRESS <b>Loch Raven VA</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>June 26-79</b>		23c NAME OF CEMETERY OR CREMATORY <b>Brooks Chr. Cem.</b>		23d LOCATION CITY OR TOWN <b>St. Leonard</b> COUNTY <b>Calvert</b> STATE <b>Md.</b>			
24 FUNERAL DIRECTOR NAME <b>Spencer E. Sewell</b> ADDRESS <b>Prince Frederick, Md.</b>				25a DATE REC'D. BY REGISTRAR <b>JUN 27 1979</b>		25b REGISTRAR'S SIGNATURE <b>L. H. McLeod</b>			

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>AMOS W. GARDNER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 9 79</b>			2b. HOUR <b>A.M.</b>			
3. SEX <b>MALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 - 10 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>76</b>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTO MD</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD			
12. CITY OR TOWN OF DEATH <b>BALTO MD</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4033 WOODHAVEN</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>BALTO</b> 13c. CITY OR TOWN <b>BALTO</b>					17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18. STREET ADDRESS <b>4333 WOODHAVEN</b>		
19. FATHER'S NAME FIRST MIDDLE LAST <b>RUFUS GARDNER</b>					20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JENNIE GARDNER</b>				
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		22. SOCIAL SECURITY NO. <b>216-10-2934</b>		23. INFORMANT ADDRESS <b>PALLIVE GARDNER 4033 WOODHAVEN</b>					
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>chronic myelocytic leukemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 years</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
25. DATE OF OPERATION			26. CONDITION FOR WHICH OPERATION WAS PERFORMED			27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			34. LOCATION STREET CITY OR TOWN COUNTY STATE			
35. I certify that (I) (the hospital) attended the deceased from <b>Autumn</b> , 19 <b>76</b> , to <b>June 9</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>June 7</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
36. SIGNATURE <b>William P. Vaughan M.D.</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						37. DATE SIGNED <b>6/11/79</b>			
38. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William P. Vaughan</b>						39. ADDRESS <b>600 N. Wolfe Street, Balto, MD</b>			
40. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			41. DATE <b>6-13-79</b>		42. NAME OF CEMETERY OR CREMATORY <b>Balto Natl Park</b>		43. LOCATION CITY OR TOWN COUNTY STATE <b>LAUREL MD</b>		
44. FUNERAL DIRECTOR NAME <b>Margaretta R Brown</b> ADDRESS <b>3106 Waelwolk</b>						45. DATE REC'D. BY REGISTRAR <b>JUN 13 1979</b>		46. REGISTRAR'S SIGNATURE <b>Patricia K. Bandy</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 14147 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARGARET M. GARDNER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>June 9th, 1979</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 16th, 1891</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto City</b>		8. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE GIVE STREET ADDRESS) <b>1111 Park Avenue Apt. 614</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE <b>Md.</b>	
13b. COUNTY <b>Balto City</b>		13c. CITY OR TOWN <b>Balto City</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>1111 Park Avenue</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Schott</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Snyder</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>214-22-1736-D</b>		17. INFORMANT ADDRESS <b>Miss Irene Gardner- 1111 Park Ave Apt. 614</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>19 76</b> to <b>6.4</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6.4</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.		22b. SIGNATURE <b>J. Kleeman</b> MD. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED <b>6.11.79</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES KLEEMAN</b>		22e. ADDRESS <b>7600 OSLER DRIVE</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/12/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto City</b>		24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home 6500 York Rd. 21212</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>Jeffrey McCreedy</b>					





FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 4 1 4 8

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Rosie Gardner</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>6-15-79</i>		2b. HOUR MIN <i>4 30 A.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 10 02</i>	
6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <i>77</i>		8. IF UNDER 24 HRS HOURS MIN. <i>77</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Balto.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Provident Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Balto.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Unkn</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Unkn</i>		16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <i>Md. Balto. Balto.</i>	
17. INFORMANT ADDRESS <i>Robert Isaac 4610 PenLucy Rd.</i>		18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		19. SOCIAL SECURITY NO. <i>215-14-5586</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardia pulmonary arrest</i> <i>4140</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ventricular Fibrillation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <i>Arteriosclerotic Heart-Disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>6 10 19 79</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>6-15-79</i> to <i>6-15-79</i> , that (I) (we) last saw the deceased alive on <i>6-15-79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>H. Devadoss</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>6/11/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>H. Devadoss</i>		22e. ADDRESS <i>Provident Hospital</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6/20/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Anne Arundel Co., Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Wm C March F/H</i>		ADDRESS <i>1101 E. North Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 19 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Robert Isaac</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 1 4 1 4 9			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Henrietta Garland</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>6-5-79</i>		2b. HOUR <i>2:25 AM</i>	
3 SEX <i>Female</i>		4 RACE <i>Jewish white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4-12-98</i>		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <i>81</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York City</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. city</i>	
10 CITY OR TOWN OF DEATH <i>Balto. city</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Levin Dale Hebrew Center Hosp</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	
13a. STATE <i>MD.</i>				13b. COUNTY <i>Balto</i>		13c. CITY OR TOWN <i>Balto</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Jacob Ferdinand</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE <i>Anna</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>093-01-7350</i>		17 INFORMANT <i>STANLEY GARLAND</i>		18 ADDRESS <i>221 STONEY RUN LA., APT. G-2</i>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>410- MYOCARDIAL INFARCTION</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 DAYS</i>			
IMMEDIATE CAUSE (a) <i>410-</i>				DUE TO, OR AS A CONSEQUENCE OF (b) <i>ARTEROSCLEROSIS</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>2-25</i> , 19 <i>77</i> , to <i>6-5</i> , 19 <i>79</i> , that (1) (we) last saw the deceased alive on <i>6-5</i> , 19 <i>77</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did not) saw the body after death.							
22b. SIGNATURE <i>Marcel Roscher</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>6-5-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARCEL ROSCHER</i>				22e. ADDRESS <i>LEVINDALE</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>JUNE 6, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>BNAI ISRAEL</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>B BALTIMORE MARYLAND</i>	
24. FUNERAL DIRECTOR NAME <i>SOL LEVINSON &amp; BROS., INC.</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 13 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Patricia...</i>	
6010 REISTERSTOWN RD., BALTO., MD 21215							



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 4 1 5 0

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HARRY ERNEST GARRISON</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>6 / 7 / 79</b>		2b. HOUR MIN <b>1.30 P</b>
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 26 20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LUTHERAN HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>MD.</b>		13b. COUNTY	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>John GARRISON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARGARET</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214 167 083</b>		17. INFORMANT ADDRESS <b>Ethel RANDALL SAME</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cerebrovascular Accident Pneumonia</b>				
19a. DATE OF OPERATION <b>-</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>May 10</b> , 19 <b>79</b> , to <b>June 7</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>June 7</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Araya Chansanchai</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6/7/79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARAYA CHANSANCHAI</b>		22e. ADDRESS <b>Lutheran Hospital</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>6-13-78</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. Md.</b>
24. FUNERAL DIRECTOR NAME <b>Vernon R. Bailey</b>		ADDRESS <b>1348 Calhoun ST.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1979</b>
		25b. REGISTRAR'S SIGNATURE <b>Jeffrey McHenry</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Handwritten notes on lined paper, including the word "Bones" and other illegible text.

Handwritten notes on lined paper, including the word "Bones" and other illegible text.

CHITIN

BOX BOTTOM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
CHARLES E GARRISS		Male		white	
5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
Feb. 17, 1930		49 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
Baltimore, Md.		USA			
9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
BALTIMORE CITY MD.		Baltimore		THE JOHNS HOPKINS HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Carpenter		Construction		13b. STREET ADDRESS	
				1624 William Avenue 21221	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Edward Garris		Agnes Fisher		Yes	
17a. SOCIAL SECURITY NO.		17b. INFORMANT		17c. ADDRESS	
217-24-6395		John E. Garriss, brother		1325 Northern Pkwy. 21239	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2041 DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST		GASTROINTESTINAL HEMORRHAGE			
(b)		CHRONIC LYMPHOCYTIC LEUKEMIA			
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
INTERSTITIAL PNEUMONITIS, RESPIRATORY FAILURE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
22a. I certify that (R) (this hospital) attended the deceased from 5/7 19 79, to 6/1 19 79, that (S) (we) lost saw the deceased alive on 6/1 19 79, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.		22b. SIGNATURE J. E. Garriss MD		22c. DATE SIGNED 6/1	
22a. PHYSICIAN'S NAME (TYPE OR PRINT)		22b. ADDRESS		22c. DATE SIGNED	
J. E. Garriss MD		BALT. CITY Hospital 4994 EASTON AVE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		6/4/79		Oak Lawn Cemetery	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Bruzdzinski Funeral Home PA 1407 Old Eastern Ave		JUN 5 1979			

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14152

1. DECEASED NAME (TYPE OR PRINT) John C. Gaskins, Jr.			2a. DATE KNOWN OF DEATH ESTIMATED 6 29 19 79			2b. HOUR M		
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 4 8 72	6. AGE (IN YEARS LAST BIRTHDAY) 7 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 6 29 19 79		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD		
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2517 W. Fayette St.			
14. FATHER'S NAME FIRST MIDDLE LAST John C. Gaskins, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Paula Matthews				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Paula Matthews 2517 W. Fayette St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> 8147 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 7:40M. 6 29 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) pedestrian struck by auto			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 500 Blk. N. Carey St. Balto. MD			
22. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) M.D. Deputy Chief			DATE SIGNED 6/30/79	
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn St. Balto., MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/3/79		23c. NAME OF CEMETERY OR CREMATORY Western Star Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUL 2 1979		25b. REGISTRAR'S SIGNATURE <i>Robert M. Brady</i>





TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Minnie L. Gentry			2a. DATE OF DEATH MONTH DAY YEAR 6/4/79			2b. HOUR 12 PM				
3. SEX F		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 18 13		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.				
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John Deaton Med. C				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1528 E. Biddle Street	
14. FATHER'S NAME FIRST MIDDLE LAST James Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-01-8783		17. INFORMANT ADDRESS Herbert Gentry 1528 E. Biddle St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Renal Failure Chronic 3429 DUE TO, OR AS A CONSEQUENCE OF (b) Old Hemiplegia (c) DUE TO, OR AS A CONSEQUENCE OF And Lethargy								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9-18 1978 to 6-4 1979, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature]					22c. DATE SIGNED 6/4/79			22d. PHYSICIAN'S NAME (TYPE OR PRINT) DSSAWHAY		
22e. ADDRESS 611 S. Charles St. - Balto 212250										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/8/79		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR NAME Wm C March F/H					25a. DATE REC'D. BY REGISTRAR JUN 5 1979		25b. REGISTRAR'S SIGNATURE [Signature]			
ADDRESS 1101 E. North Ave.										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CLAUDE W. GEOGHEGAN</b>			2a. DATE OF DEATH MONTH <b>06</b> DAY <b>25</b> YEAR <b>79</b>		2b. HOUR <b>3A</b> M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>6</b> DAY <b>16</b> YEAR <b>06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>US</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>N.</b> LAST <b>Geoghegan</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Ella</b> MIDDLE <b>Hurley</b> LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>1942-1943</b>		17. INFORMANT <b>Mrs. Emily A. Geoghegan</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bil. cerebrovascular Accident</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>5-29-</b> 19 <b>79</b> , to <b>6-25-</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6-25-</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Prasad A. Iravavaran</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/25/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PRASAD A. IRAGAVARAPU</b>		22e. ADDRESS <b>GOOD SAMARITAN HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-27-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dor. Mem. Park</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge, Dor. Md.</b>		24. FUNERAL DIRECTOR NAME <b>Thomas Funeral Home Box 348 Maryland</b> ADDRESS <b>Cambridge</b>			
25a. DATE REC'D. BY REGISTRAR <b>JUN 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>			

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 1 5 5

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Alice</b> FIRST <b>Gibson</b> LAST			2a. DATE OF DEATH MONTH <b>06</b> DAY <b>12</b> YEAR <b>79</b>		2b. HOUR <b>6:35</b> M
3 SEX <b>F</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH <b>7</b> DAY <b>12</b> YEAR <b>07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales/Ady</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Store</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>BALTO.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>2026 MADISON AVE.</b>	
14. FATHER'S NAME FIRST <b>Alfred</b> MIDDLE <b>Gibson</b> LAST <b>Sussie</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Watts</b> MIDDLE <b>Watts</b> LAST <b>Watts</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> 16b. SOCIAL SECURITY NO. <b>220-14-1760</b> 17. INFORMANT ADDRESS <b>2026 MADISON BALTIMORE</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>1830</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1830</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chemo/radiation</b>					
19a. DATE OF OPERATION <b>6/12/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>metastatic carcinoma</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>5/25</b> , 19 <b>79</b> , to <b>6/12</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/12</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Bruce E. Johnson, M.D.</b> DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6/12/79.</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Bruce E. Johnson, M.D.</b>	
22e. ADDRESS <b>Sinai Hospital</b>		22f. ADDRESS <b>Sinai Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>6/18/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b> STATE <b>MD.</b>	23e. DATE REC'D. BY REGISTRAR <b>JUN 14 1979</b>
24. FUNERAL DIRECTOR NAME <b>Chatman F.H.</b> ADDRESS <b>1701 Mc Culloch St</b>		25. REGISTRAR'S SIGNATURE <b>Barney K. Bandy</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

OFFICE OF THE CHIEF OF BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

July 1, 1917

Very respectfully,  
Sincerely,  
Respectfully,  
Very truly,  
Very respectfully,  
Very truly,  
Very respectfully,  
Very truly,

1917

1917

22 21

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

July 1, 1917

July 1, 1917

July 1, 1917

July 1, 1917

July 1, 1917

July 1, 1917

July 1, 1917

July 1, 1917

July 1, 1917

July 1, 1917

July 1, 1917

July 1, 1917



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 1 5 6

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>REMUS J. GIBSON</b>			2a. DATE OF DEATH MONTH <b>JUNE</b> DAY <b>6-22-79</b> YEAR <b>1979</b>		2b. HOUR <b>10:55 AM</b>
3. SEX <b>MALE</b>	4. RACE <b>NEGRO</b>	5. DATE OF BIRTH MONTH <b>OCT.</b> DAY <b>22</b> YEAR <b>1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PROVIDENT HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TAILOR + PRESSER</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>BALTO.</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>ALEXANDER</b> MIDDLE <b></b> LAST <b>GIBSON</b>		15. MOTHER'S MAIDEN NAME FIRST <b>KATIE</b> MIDDLE <b></b> LAST <b>EBBS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-01-7177</b>		17. INFORMANT <b>MARGARET GIBSON</b> ADDRESS <b>34 LINCOLN AVENUE</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

1519 IMMEDIATE CAUSE (a) **Cancer of Stomach & Metastases.**

DOE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DOE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION <b>6-22-79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer of Stomach &amp; Metastases.</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6-22-79</b> to <b>6-22-79</b> , that (I) (we) last saw the deceased alive on <b>6-22-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>B. Narayana</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6-22-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. NARAYANA</b>		22e. ADDRESS <b>Provident Hospital Baltimore, MD - 21207.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>06/27/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE BALTO. MD</b>	
24. FUNERAL DIRECTOR NAME <b>MARSHALL W. JONES, JR.</b>		ADDRESS <b>4101 EDMONDSON AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 27 1979</b>	25b. REGISTRAR'S SIGNATURE <b>Fitzpatrick</b>

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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CONFIDENTIAL  
U.S. GOVERNMENT PRINTING OFFICE  
1964 O - 345-000

(M)

1. The first part of the report is a summary of the work done during the past year. It includes a description of the methods used, the results obtained, and a discussion of the problems encountered. The second part of the report is a detailed account of the work done during the past year. It includes a description of the methods used, the results obtained, and a discussion of the problems encountered. The third part of the report is a summary of the work done during the past year. It includes a description of the methods used, the results obtained, and a discussion of the problems encountered.

2. The first part of the report is a summary of the work done during the past year. It includes a description of the methods used, the results obtained, and a discussion of the problems encountered. The second part of the report is a detailed account of the work done during the past year. It includes a description of the methods used, the results obtained, and a discussion of the problems encountered. The third part of the report is a summary of the work done during the past year. It includes a description of the methods used, the results obtained, and a discussion of the problems encountered.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14157	
1. FOR STATE REGISTRAR										7a. DATE KNOWN OF DEATH	
1. DECEASED NAME FIRST MIDDLE LAST <b>THEODORE GIBSON</b>										ESTIMATED MONTH DAY YEAR <b>6 5 19 79</b>	
3. SEX male 4. RACE black 5. DATE OF BIRTH MONTH DAY YEAR <b>8 30 25 53</b> 6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN <b>53</b> 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 5 19 79</b>										2b. HOUR <b>2:15</b>	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>Mercy Hospital</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS <b>1023 St. Paul St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Gibson</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Delancie Meadows Gibson</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b> 16b. SOCIAL SECURITY NO. <b>234-32-6009</b>										17. INFORMANT ADDRESS <b>Nathaniel Gibson 3410 Caton Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic cardiovascular disease and fibrosis of liver</b> (b) <b>disease and fibrosis of liver</b> (c) <b>disease and fibrosis of liver</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Margarita A. Korell</b> TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER DATE SIGNED <b>6/6/79</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b> ADDRESS <b>111 Penn Street</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>6/8/79</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus Md.</b>											
24. FUNERAL DIRECTOR NAME <b>WM. C. MARCH F/H</b> ADDRESS <b>1101 E. North Ave.</b> 25a. DATE REC'D. BY REGISTRAR <b>JUN 8 1979</b> 25b. REGISTRAR'S SIGNATURE <b>Pietro M. M...</b>											

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George A Gilley			2a. DATE OF DEATH MONTH DAY YEAR 6 17 79			2b. HOUR 9:10 AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 03 21 06		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUGGESTED BY STRAIGHT LINE) ST AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST		12b. KIND OF BUSINESS OR INDUSTRY KOPPERS, INC.	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1806 HARMAN AVENUE, 21230	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE A GILLEY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SADIE HYLE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-01-9122		17. INFORMANT ADDRESS EDITH B. GILLEY, 1806 HARMAN AVENUE, 21230					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>ventricular fibrillations</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DOA 6/12/79 DOD 6/17/79	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Sayer disorder &amp; H<sub>2</sub>O Previous MI. Permanent Pacemaker</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>D. S. KALARIA</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 06-17-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. S. KALARIA				22e. ADDRESS 900 CATON AVE. BALTIMORE, MD 21229			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 06-20-79		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK ELKTRIDGE		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE HOWARD MD.	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.				25. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE, FIRST, MIDDLE, LAST) <b>Telesfor B. Gilvickas</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 20 79</b>			2b. HOUR <b>2:46 P.M.</b>				
3. SEX <b>M</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 9 17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALT. MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MD. Cup Co.</b>		
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Owings Mills</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>9213 Lyons Mill Rd.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph — Gilvickas</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary — Rimkus</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>166-16-4032</b>		17. INFORMANT <b>Mrs. Ruth Gilvickas</b>				ADDRESS <b>9213 Lyons Mill Rd., Owings Mills, MD 21117</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Renal Failure - ASCVD</b> <b>4275</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiopulmonary Arrest.</b> (c) <b>Adult - Diabetes Mellitus</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Adult - Diabetes Mellitus</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>July 78</b> , 19 <b>79</b> , to <b>June</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>29 June</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Frank Westbrook Braxton MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>20 June 79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FRANK Westbrook Braxton</b>			22e. ADDRESS <b>SINAI HOSPITAL - Balt. MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>6/23/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore MD</b>			
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, P.</b> ADDRESS <b>8728 Liberty Rd., Randallstown, MD 21133</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Helen K. Brady</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the Division of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14160

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>MARIE</b>			2a DATE OF DEATH MONTH DAY YEAR <b>6/29/79</b>			2b HOUR M <b>1</b>		
3 SEX <b>Female</b>			4 RACE <b>Negroid</b>			5 DATE OF BIRTH MONTH DAY YEAR <b>2-26-18</b>		
6 AGE (IN YEARS LAST BIRTHDAY) <b>61</b>			7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>			7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>city of Baltimore</b> MD					
10 CITY OR TOWN OF DEATH <b>Balto.</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
12b KIND OF BUSINESS OR INDUSTRY			13a STREET ADDRESS <b>4109 Forest Pk. Ave.</b>			13b INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>James Barnes</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Davis</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. <b>217 126381</b>			17 INFORMANT ADDRESS <b>Eleanora Janey same</b>		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>fatal acute myocardial infarction</b> 4140 DUE TO, OR AS A CONSEQUENCE OF Cardiac Arrhythmia (b) <b>Severe Coronary Arterioscl.</b> DUE TO, OR AS A CONSEQUENCE OF Myocardial Infarction - Diabetic Mellitus (c) <b>Diabetic Mellitus</b> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Wound Infection Diabetes Mellitus</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION <b>6/22/79</b>			19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Diabetic ulcer of foot</b>			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>6/18</b> <b>1979</b> to <b>6/29</b> <b>1979</b> , that (I) (we) lost saw the deceased alive on <b>6/29/79 3:00 PM</b> and that in (my) (our) opinion death occurred on the <b>29th</b> day and from the causes stated above. (I) (we) (did) (did not) view the body after death. <b>supervised death at 6:35 AM</b>								
22b. SIGNATURE <b>DR. P. Edgar / Loretta L. Ryan</b>			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. P. Edgar / Loretta L. Ryan</b>		
22e. ADDRESS <b>Good Samaritan Hospital</b>			22f. ADDRESS <b>Baltimore, Md.</b>			22g. ADDRESS <b>Baltimore, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7-3-79</b>			23c. NAME OF CEMETERY OR CREMATORY <b>New Catharal Cem</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>			24 FUNERAL DIRECTOR NAME ADDRESS <b>Vernon Bailey F.H. 1348 Calhoun Street</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 3 1979</b>		
25b. REGISTRAR'S SIGNATURE <b>H. H. Brady</b>								

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 in retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. REG. NO.		14161					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES F. GLASGOW</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6-14-79</b>			2b. HOUR MIN <b>9 PM</b>		
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6-29-93</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>85</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Metalizer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bendix Co.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1120 W. 20th Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sophie Glasgow</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-18-1415</b>		17. INFORMANT ADDRESS <b>Mr. Clarence Glasgow 4607 Maine Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> (c) <b>UNCONTROLLED DIABETES MELLITUS.</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>UNCONTROLLED DIABETES MELLITUS.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 WKS.</b> <b>5 YEARS</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5-30 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5-30 1979</b> to <b>6-14 1979</b> , that (I) (we) last saw the deceased alive on <b>6-14 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Oscar E. Fernandini M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6-15-79</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>OSCAR E. FERNANDINI M.D.</b>	
				22e. ADDRESS <b>2025 W. FAYETTE ST. BALTO. MD. 21223</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 21, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Md</b>			
24. FUNERAL DIRECTOR NAME <b>Herbert E. Nutter</b>				ADDRESS <b>3035 W. North Ave.</b>		25a. DATE REC'D BY REGISTRAR <b>JUN 19 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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10  
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 1 6 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>TIMOTHY L. GLENN, Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 22 1979</b>			2b. HOUR <b>8-42 PM</b>				
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 13 16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>908 N. Arlington Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Glenn, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-05-2096</b>		17. INFORMANT ADDRESS <b>William M. Glenn 3915 Rexmere Rd.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>2859</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ANEMIA</b> (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>DIABETES MELLITUS</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (he) (this hospital) attended the deceased from <b>5-3-1979</b> , to <b>6-22-1979</b> , that (we) (we) last saw the deceased alive on <b>6-22-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Baskaran</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6-22-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SAMBANDAM BASKARAN</b>				22e. ADDRESS <b>Ashburton St. Baltmo MD 21216</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/28/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Co., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 20 1979</b>	
						25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 1 4 1 6 3 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) MARION I. GLENNIE					2a. DATE OF DEATH MONTH DAY YEAR 6-18-79					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 3, 1887		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS		7b. HOUR A M 7:55 A M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Hampton, Mass		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Belair Convalesarium			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.					13b. COUNTY Balto.		13c. CITY OR TOWN Reisterstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alfred Fearing					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adele Dow					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-34-4183		17. INFORMANT ADDRESS Mr. John R. Glennie Reisterstown, Md.						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart Failure</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Old Stroke</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>6/18/79</u> to <u>6/18/79</u> that (I) (we) last saw the deceased alive on <u>6/18/79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b. SIGNATURE <u>[Signature]</u> DEGREE <u>M.D.</u>				22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>6/18/79</u>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Luis E. Rivera, M.D.				22f. ADDRESS 50 Scott Adam Rd. Cockeysville, Maryland 21030						
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE June 20, 79		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Md.			
24. FUNERAL DIRECTOR NAME Eline Funeral Home				24b. ADDRESS Reisterstown, Md. 21136			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 22 1979 <u>[Signature]</u>			



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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14164

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JAMES W GLOVER			2a. DATE OF DEATH MONTH DAY YEAR 6-21-79			2b. HOUR 9:20 AM	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Oct. 25, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Glover		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie Booker Glover					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS James Glover 1915 Ramblewood Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA = Rt Hemiplegia 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes mellitus Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) HASCULDE CHF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6-04-1929, to 6-21-1929, that (I) (we) last saw the deceased alive on 6-21-1929, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE B. Narayana				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-21-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. NARAYANA				22e. ADDRESS Provident Hospital Baltimore, MD - 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/25/79		23c. NAME OF CEMETERY OR CREMATORY King Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, County, Md.	
24. FUNERAL DIRECTOR NAME Wm. C. March F.H./1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR JUN 26 1979		25b. REGISTRAR'S SIGNATURE R. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 4 1 6 5			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GEORGE JOSEPH GOFFA</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6 18 79</b>		2b. HOUR <b>8:00PM</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 4 20</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CZECHOSLOVAKIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE, CITY</b> MD.	
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3900 LOCH RAVEN BLVD., BALTO. MD.</b>				12a. USUAL OCCUPATION <b>fork lift operator</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. CITY <b>Baltimore</b> 13c. COUNTRY <b>overlea</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>404 OLD HOME ROAD, BALTO. 21206</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>George Goffa</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Cmar</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>165 18 1145</b>		17. INFORMANT ADDRESS <b>Mrs. Gladys Goffa 404 Old Home Road</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF lung</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1977</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>HEPATIC ENCEPHALOPATHY</b>							
19a. DATE OF OPERATION <b>6-18</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3900 LOCH RAVEN BLVD., BALTO. MD. 21218</b>			
22a. I certify that (X) (this hospital) attended the deceased from <b>5-27</b> , 19 <b>79</b> , to <b>6-18</b> , 19 <b>79</b> , that (X) (we) lost saw the deceased alive on above <b>6-18</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above <b>X</b> (we) (did) <b>X</b> view the body after death.							
22b. SIGNATURE <b>ALISON WICHMAN MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/18/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALISON WICHMAN MD</b>				22e. ADDRESS <b>Loch Raven VA Hospital</b>			
23a. BURIAL CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>6-22-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY <b>Baltimore</b> COUNTY <b>Maryland</b> STATE	
24 FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. 5305 Harford Rd. Balto; Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Linda McCreedy</b>	

COPIES

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14166	
1. DECEASED NAME (TYPE OR PRINT) <b>James Goins</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 3 79</b>	
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>517 Cathedral Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>171-16-8205</b>		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic cardiovascular disease</b> 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Virginia L. Dolan MD</b>				TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>6/7/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn Street, Balto., MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>				23b. DATE <b>6-14-79</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anthony B. G. Jr.</b> ADDRESS <b>Balt. Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 18 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Anthony B. G. Jr.</i>			



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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14167

1. DECEASED NAME (TYPE OR PRINT) <b>Henry - Golaner</b>		2a. DATE KNOWN OF DEATH ESTIMATED MONTH <input checked="" type="checkbox"/> 6 DAY 23 YEAR 19 79		2b. HOUR M 12:56 P 12:56
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 19, 1909</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>70</b> YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3106 Rosalie Avenue</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>	13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>3106 Rosalie Avenue</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob - Golaner</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth - Miller</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>216-16-5461</b>		17. INFORMANT ADDRESS <b>Mrs. Ethel Golaner same</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>L.R. Guard</b>		TITLE (SPECIFY) <b>Assistant</b>		DATE SIGNED <b>6/24/79</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, MD.</b>		ADDRESS <b>111 Penn Street, Baltimore, MD</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>June 27, 1979</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruak Inc. Baltimore, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McBrody</b>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>IRVING</b>		FIRST <b>Goldberg</b>		LAST		2a. DATE OF DEATH MONTH DAY YEAR <b>6/28/79</b>		2b. HOUR <b>6:40</b> M	
3 SEX <b>MALE</b>		4 RACE <b>W HITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2-10-1895</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Levinson Geriatric C. &amp; Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MENS CLOTHING</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>XXXXXXXXXX</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>#21215 4572 Derby Manor Drive</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>JACOB</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZABETH UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) <b>WWI-ARMY</b>		17. INFORMANT <b>MRS. GLACE E. GOLDBERG</b>		ADDRESS <b>4572 DERBY MANOR DR. #21215</b>			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b>
5070 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>aspiration</b>		<b>Weeks</b>
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>CVA</b>							
19a. DATE OF OPERATION <b>5/19/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5/19/79</b> , 19____, to <b>6/28/79</b> , 19____, that (we) last saw the deceased alive on <b>6/19/79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Joseph I Berman</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/28/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH I BERMAN</b>				22e. ADDRESS <b>Imai Hospital</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JULY 1, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>(CHIZUK AMUNO) ARLINGTON</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>	
24 FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffrey McCreedy</b>	
6010 REISTERSTOWN RD., BALTO., MD 21215							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HENRY GOLDSMITH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>06 25 79</b>		2b. HOUR <b>11:30</b> M
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>06 28 15</b>	6 AGE (IN YEARS (LAST BIRTHDAY)) <b>63</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PROPRIETOR</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>REAL ESTATE</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>MARYLAND</b>	13b. COUNTY	13c. CITY OR TOWN <b>BALTO.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>#21215 3501 CLARKS LA., APT. 1D</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MORRIS GOLDSMITH</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA ROSENBERG</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-32-4645</b>	17 INFORMANT <b>MRS. BESSIE GOLDSMITH</b>		<b>3501 CLARKS LA., APT. 1-D #21215</b>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>HEPATO RENAL FAILURE</b> 1539 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last <b>DUETO, OR AS A CONSEQUENCE OF METASTATIC ADENOCARCINOMA OF COLON</b> DUETO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>06/25 1979</b> to <b>06/25 1979</b> , that (I) (we) lost saw the deceased alive on <b>06/25 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE <b>Raymond J. Altieri</b>		DEGREE <b>MD</b>		22c. DATES SIGNED <b>06/25/79</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAYMOND J. ALTIERI</b>		22e. ADDRESS <b>SINAI HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>JUNE 27, 1979</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CHIZUK AMUNO</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>	
24 FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> NAME ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 3 1979</b>	25b. REGISTRAR'S SIGNATURE <b>Henry McBrady</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>DAVID</b>		FIRST <b>Goldstein</b>		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR <b>6-4-79</b>		2b HOUR <b>9:55A</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>JAN. 26, 1890</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF-EMPLOYED</b>		12b KIND OF BUSINESS OR INDUSTRY <b>CLOTHING MFG.</b>					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE <b>MARYLAND</b>		13b COUNTY <b>BALTIMORE</b>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS <b>2nd FL. 5815 PARK HTS. AVE. #21215</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>ISAAC GOLDSTEIN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>216-32-6454</b>		17 INFORMANT <b>MISCHA SCHNIDER</b> ADDRESS <b>3198 OLD POST DR. BALTO., MD 21208</b>							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Renal Failure</b> 2030										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple Myeloma</b>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>5/31, 1979</b> to <b>6/4, 1979</b> , that (I) (we) lost saw the deceased alive on <b>6/4, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Juan Arguinzon</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/4/79</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Juan Arguinzon</b>		22e. ADDRESS <b>SINAI HOSPITAL</b>									
23a BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>JUNE 5, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH EL MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>RANDALLSTOWN BALTO. MD</b>					
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Frederick McReddy</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					7 9 1 4 1 7 1 REG. NO.									
1. FOR STATE REGISTRAR					1. DECEASED NAME FIRST MIDDLE LAST <b>Reba Goldstein</b>					2a. DATE OF DEATH MONTH DAY YEAR 2b HOUR <b>June 3 1979 8P</b>				
3 SEX <b>Female</b>		4 RACE <b>W HITE</b>		5 DATE OF BIRTH DAY MONTH YEAR <b>JAN 15 1897 1893</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b>		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.								
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Levin Dale Hebrew Geriatric Center</b>				12a USUAL HOUSEHOLD (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>						
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>md</b>					13b COUNTY <b>BALTIMORE</b>		13c CITY OR TOWN <b>BALTIMORE</b>		13d INSIDE CITY LIMITS? <b>XXXX NO</b>		13e STREET ADDRESS <b>APT. 508 #21215 2500 N. Belvedere Ave</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>CHAIM DAVID MARGOLIS</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSE ELLA SEIDMAN</b>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>215-24 9040</b>		17 INFORMANT <b>MR. HARLAN MARGOLIS</b>				2814 MARNAT RD. #21209						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable MYOCARDIAL INFARCT</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>H10 -</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b> <b>YEARS</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>THROMBOCYTOPENIC PURPURA, CHRONIC</b>														
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <b>12/7</b> 19 <b>78</b> to <b>6/3</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/3</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (I) (did not) view the body after death														
22b. SIGNATURE <b>H. MARGOLIS</b> DEGREE								22c. DATE SIGNED <b>6/4/79</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. ZAW-LIN, MD</b>				22e. ADDRESS <b>Levin Dale Hebrew Geriatric Center</b>										
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JUNE 4, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BNAI ISRAEL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>								
24 FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Putney Helmsley</b>								
6010 REISTERSTOWN RD., BALTO., MD 21215														

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TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 1 4 1 7 2 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ANGELINE GONZALEZ				2a. DATE OF DEATH MONTH DAY YEAR JUNE 12 1979				2b. HOUR 9:20 PM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 13-22		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD				13b. COUNTY ✓		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1321 RIBBY CT	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES MARINORZI				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUBY MARKER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS FRANCIS WHITE SOUTHERN AVE 2801					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-pulmonary Arrest</u> <u>0543</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertension, renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>overwhelming sepsis, cerebral edema</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 minutes 29 hrs 72 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Morbid obesity; Pickwick Syndrome; ? CNS bleed</u>											
19a. DATE OF OPERATION 6-8-79				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Obstruction; Pterops Encephalitis</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/10 1979 to 6/12 1979, that (I) (we) lost saw the deceased alive on 6/12 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.											
22b. SIGNATURE Peter Rock				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/12/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Rock				22e. ADDRESS Johns Hopkins Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 6-15-79		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore			
24. FUNERAL DIRECTOR NAME John M. Weber				ADDRESS K. S. S. B. R. C. H. E. S. T. E. R.				25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE History McBrady	



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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BERTRAM</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-11-79</b>			2b. HOUR <b>2:14</b> P.M.			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAR. 12, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF-EMPLOYED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GEN. ADVERT.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4005 N. CHARLES ST. #21218</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ISAAC GOODMAN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII 335-01-7495</b>		17. INFORMANT <b>MRS. BETTY GOODMAN</b>		4005 N. CHARLES ST.		#21218	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> <b>5621</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>LOWER GI BLEED</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIVERTICULOSIS</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr.</b> <b>4 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ANTICOAGULANT THERAPY</b>									
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>6/7</b> 19 <b>77</b> to <b>6/11</b> 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>6/11</b> 19 <b>79</b> , and that (1) (we) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>P. Disharoon, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>6/11/79</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PATRICIA DISHAROON, M.D.</b>				22c. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JUNE 12, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BNAI ISRAEL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 13 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Pitney Kelcey</b>			

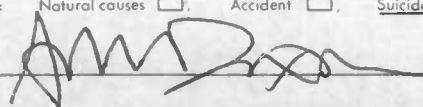

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #M 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14174	
1. DECEASED NAME (TYPE OR PRINT) <b>Terry Lee Goodwin</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 12 19 79</b>										2b. HOUR <b>M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 16 1955</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>24</b> YRS		7. IF UNDER 24 YRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD <b>6 12 19 79</b>		2d. HOUR <b>7:43A</b>		2e. MIN <b>M</b>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>									
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1908 Griffith Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Calvert Contr.</b>									
13a. STATE <b>Maryland</b>				13b. COUNTY <b>n/a</b>		13c. CITY OR TOWN <b>Balto. City</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1908 Griffith Ave.</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward W. Goodwin, Jr.</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah E. Dawson</b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>216-62-0140</b>		17. INFORMANT (sister) ADDRESS <b>Baltimore, Maryland</b>				17. INFORMANT (sister) ADDRESS <b>Baltimore, Maryland</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Perforating gunshot wound of chest (rifle)</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 6 12 19 79</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>self inflicted</b>													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1908 Griffiths Ave. Balto. MD</b>													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE 				M.D. <b>Assistant</b>				DATE SIGNED <b>6/12/79</b>				MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>June 15, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Balto. Co. Md.</b>											
24. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home</b>				ADDRESS <b>Glen Burnie, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1979</b>				25b. REGISTRAR'S SIGNATURE 									

1414

May 10 1952

Received

100.00

Amount

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David A. Davidson, Jr.

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(later)

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Records of Cunningham

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 1 HOUR AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 114175	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Leon H. Gordon</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 17 19 79</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7-1-1923</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>55</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD <b>6 17 19 79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BALTO. City</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>				13b. COUNTY <b>BALTO.</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2125 DENISON ST.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Gordon</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen GASKIN'S</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>217-14-0846</b>				17. INFORMANT ADDRESS <b>Juanita Skeeter</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of mouth (handgun)</b> <b>9550</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							
20. AUTOPSY? <b>HEAD ONLY</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10:24xx 6 17 19 79</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>self inflicted</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>2125 N. Dennison St. Balto. MD</b>			
22a. I certify that I took charge of the remains described above, held on <b>Autopsy</b> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>6/18/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6-22-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Vernon R. Bailey 1348 Calhoun St.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

2 7 1 4 1 1 A

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>FRANK GORNALL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6/4/79</b>			2b. HOUR <b>12:00 AM</b>			
3 SEX <b>MALE</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>10 23 95</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.			
10 CITY OR TOWN OF DEATH <b>Balto</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital of Md.</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Fiber Corp.</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13a STATE <b>md.</b>		13b COUNTY <b>Allegany</b>		13c CITY OR TOWN <b>Cumberland</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>114 1/2 Greene St.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Gabor F. Gornall</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mollie Beall</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO. <b>W.W.I</b>		17 INFORMANT <b>Margaret Jeffers</b>		ADDRESS <b>Lacono, Colorado 80516</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest.</b> <b>5990</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Septicemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>LUNG ? Decubitus ulcer</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5-2-79</b> , 19____, to <b>6-4-79</b> , 19____, that (I/we) last saw the deceased alive on <b>6-4-79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Sissai Awolake</b>						DEGREE <b>M</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sissai Awolake</b>						22e. ADDRESS <b>Lutheran Hospital</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>June 6, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany, Md.</b>		
24 FUNERAL DIRECTOR NAME ADDRESS <b>Kight Funeral Home Cumberland, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Pat [Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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RECEIVED  
JAN 10 1964  
U.S. AIR FORCE





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				2b. HOUR	
JOHN					June 1, 1979				9:30 a.m.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
Male		White		6/13/97		81		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Baltimore		U. S. A.				Baltimore City MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		Pleasant Manor Nursing Home				unknown		unknown		
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.							Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
Edward Gorsuch					Mary					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes					220-34-6349		Pleasant Manor Nursing Center 4615 Park Heights Ave., 21215			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY.										
IMMEDIATE CAUSE (a) <i>Broncho pneumonia</i>										
4280										
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bronchial congestion</i>										
DUE TO, OR AS A CONSEQUENCE OF (c) <i>CHF</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Myelomatosis, Resorptive abuse</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED						
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2						
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION						
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>3/9/79</i> , 19____, to <i>6/1/79</i> , 19____, that (I) (we) last saw the deceased alive on <i>5/23/79</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
<i>Humberto Certeza</i>								<i>June 1, 1979</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
Humberto Certeza, M. D.		1206 Goucher Blvd., Towson, Md. 21204								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. REGISTRAR'S SIGNATURE		
Burial		6/4/79		Clarion Cemetery		Clarion Co. Pa.				
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Law Funeral Home 4611 Park Heights Ave.						JUN 6 1979		<i>Patricia McBrady</i>		

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

3

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 14178

1. DECEASED NAME (TYPE OR PRINT) ELMIRA		FIRST GOUCH		LAST		2a. DATE OF DEATH MONTH DAY YEAR JUNE 16 79		2b. HOUR 1 15 P M	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 12 14 20		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MD. HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1561 Appleton St	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANDONIA MOXLEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-14-5274		17. INFORMANT Viola Neal		ADDRESS 2011 Ruxton Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1844 CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) RENEAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) RECURRENT EPIDERMOID CARCINOMA OF UULVA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 3/05/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GROIN WOUND DEHISCENCE				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from MARCH 2, 19 79, to JUNE 16, 19 79, that (I) (we) lost saw the deceased alive on JUNE 16, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
23a. SIGNATURE S. KOEHLER M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				23c. DATE SIGNED 6/16/79	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) S. KOEHLER				23d. ADDRESS UNIV. OF MD. HOSP					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/21/79		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE [Signature]	



FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14179

1. DECEASED NAME (TYPE OR PRINT) <b>Gloria</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 8 19 79</b>			2b. HOUR <b>11:35</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 8, 1920</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 8 19 79</b>	7d. HOUR <b>A M</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital (STU)</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>PIKESVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY SHAPIRO</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DENA BERNSTEIN</b>		16. SOCIAL SECURITY NO. <b>215-12-4858</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-12-4858</b>		17. INFORMANT ADDRESS <b>MR. JAY H. GOULINE 1416 MASON ST. #21217</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Smoke Inhalation</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2:02 AM 6 6 19 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject caught in apartment fire</b>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Apt. 406, 1 Slade Avenue, Pikesville, Baltimore, Md.</b>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>		TITLE (SPECIFY) <b>Assistant</b>		DATE SIGNED <b>6/8/79</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>		ADDRESS <b>111 Penn Street</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6-10-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>REISTERSTOWN BALTO. MD</b>
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 13 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Fitzroy Hebrudy</i>
ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>						

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT SHOULD BE EXECUTED WITHIN 72 HOURS. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 06 07 72 1 41 80						
1. DECEASED NAME (TYPE OR PRINT) John S Graham, Jr.						2a. DATE OF DEATH MONTH DAY YEAR June 25, 1979		2b. HOUR 12:10a M	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6 7 1972		6. AGE (IN YEARS LAST BIRTHDAY) 7 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 47 WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH 33 Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY School	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD.		13b. CITY OR TOWN Annapolis		13c. STREET ADDRESS 1022 Old Bay Ridge Rd.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST John S. Graham				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sharon Ehlert					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS John S. Graham Sr. #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC-PULMONARY ARREST 2080 DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA & BLEEDING DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE LEUKEMIA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate 2 weeks 17 mos	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): HYPOKALEMIA, HYPOXIA, NEUTROPENIA.									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —					
22a. I certify that (I) (this hospital) attended the deceased from 19 6/25, to 19 79, that (I) (we) last saw the deceased alive on 6/25 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Carolyn Schanck MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 6/25/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CAROLYN SCHANCK				22e. ADDRESS JOHNS HOPKINS HOSPITAL.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/27/79		23c. NAME OF CEMETERY OR CREMATORY Woodhawn		23d. LOCATION CITY OR TOWN COUNTY STATE Easton MD.			
24. FUNERAL DIRECTOR NAME ADDRESS John M. Lefkowitz, Inc.				25a. DATE REC'D. BY REGISTRAR JUN 27 1979		25b. REGISTRAR'S SIGNATURE Rickey McBrady			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 14181									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Josephine						Graham		6 2 79		5 A M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
FeMale		Black		6 10 15		63 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Fla.		USA				Balto City MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Balto.		Balto. City Hospital						Housewife			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Md						Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3719 Woodbine Ave	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Charlie Stevens Sr.		Abbey Chipp									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No						Robert D. Graham 3719 Woodbine Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
585- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) <u>Chronic Renal Failure</u>											
(c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6/2</u> 19 <u>79</u> to <u>6/2</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/2</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <u>Simon T. Baur</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>6/2/79</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Simon Barden MD</u>		22e. ADDRESS <u>B.C.H.</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>6-7-79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge Cem.</u>		23d. LOCATION CITY OR TOWN <u>A. A. CO.</u> COUNTY STATE <u>Md.</u>					
24. FUNERAL DIRECTOR NAME <u>Isaiah L. Brown &amp; Son PA 1913 W. Balto.</u>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <u>JUN 6 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Isaiah L. Brown</u>					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14182	
1. DECEASED NAME (TYPE OR PRINT) <b>Gloria Grant</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <b>6</b> DAY <b>8</b> YEAR <b>1979</b>		2b. HOUR <b>M</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>18</b> YEAR <b>1947</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>31</b> YRS.		7. IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		2c. DATE PRONOUNCED DEAD MONTH <b>6</b> DAY <b>8</b> YEAR <b>1979</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Ma.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1424 Argyle Ave.</b>			
14. FATHER'S NAME FIRST <b>Willie James</b> MIDDLE <b></b> LAST <b></b>				15. MOTHER'S MAIDEN NAME FIRST <b>Ann Mae</b> MIDDLE <b>Stevenson</b> LAST <b></b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>075-38-7847</b>		17. INFORMANT ADDRESS <b>James Nettles 131 St Nicholas Ave. N.Y.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Gunshot Wound of Head (handgun)</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>9650</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <b>8:50</b> P.M. MONTH <b>6</b> DAY <b>8</b> YEAR <b>1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject shot by assailant</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET <b>1424 Argyle Ave.,</b> CITY OR TOWN <b>Baltimore</b> COUNTY <b></b> STATE <b>Md.</b>					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER										DATE SIGNED <b>6/9/79</b>	
ACTUAL SIGNATURE <b>Margie A. Korell</b>				EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6-16-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairlawn Cem.</b>		23d. LOCATION CITY OR TOWN <b>N.Y., N.Y.</b> COUNTY <b></b> STATE <b></b>			
24. FUNERAL DIRECTOR <b>Vernon Bailey F.H. 1340 Calhoun Street</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 4 1 8 3	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST ELIZABETH		MIDDLE C		LAST GRAUER		2a. DATE OF DEATH MONTH DAY YEAR 6-16-79		2b. HOUR 2:20 PM	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN 2 1905		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. CITY BALTO.				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 441 MASEFIELD RD			
14 FATHER'S NAME FIRST MIDDLE LAST HOWARD WEST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CECILIA O'MARA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-36-9080		17 INFORMANT ADDRESS 941 CLARENCE GRAUER, MASEFIELD RD.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> 3989 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute pulmonary Edema.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Rheumatic Heart disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>and recent acute myocardial infarction</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6-12-</u> 19 <u>79</u> , to <u>6-16</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6-16-79 at 2:30 P.M.</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE P. VANKINENI		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> 22c. DATE SIGNED 6/16/79				MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. VANKINENI		22e. ADDRESS 900 CATON AVE.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-19-79		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.					
24 FUNERAL DIRECTOR NAME WEBER FEDERAL HOME		ADDRESS 5311		25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE [Signature]					

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YTD 2017

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>Herbert M. Greaser Sr.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>June 22, 1979</b>		2b. HOUR M		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 11, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>434 Fawcett Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Roofer</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>		13c. STREET ADDRESS <b>434 Fawcett Street</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Greaser</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elisha Parks</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF KNOWN, GIVE YEAR OR DATES) <b>WW 11 218 10 2997</b>		17. INFORMANT <b>Mary E. Greaser</b>			ADDRESS <b>Same</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerosis</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>years</b>								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Aortic Stenosis, Chronic Lung Disease</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/11</b> 19 <b>79</b> , to <b>6/20</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/20</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.									
22b. SIGNATURE <b>Daniel Lindenstruth M.D.</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>22 June 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Daniel Lindenstruth</b>					22e. ADDRESS <b>Maryland General Hospital</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>25 June 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Burgee Funeral Home</b>					ADDRESS <b>3631 Falls Rd. 21211</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 25 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Brady</b>

BP



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

(Dorothy B.)

1 DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

BERNICE D. GREEN

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

6 27 '79 9:45 P.M.

3 SEX

F.

4 RACE

B.

5. DATE OF BIRTH

MONTH

DAY

YEAR

7 15 20

6 AGE (IN YEARS LAST BIRTHDAY)

58

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN

7a BIRTHPLACE  
(STATE OR FOREIGN  
COUNTRY)

Pa.

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10 CITY OR TOWN OF DEATH

Balto.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

North Charles Gen.

12a USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)12b KIND OF BUSINESS OR  
INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Md.

13b COUNTY

13c CITY OR TOWN

Balto.

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS

822 E. Coldspring Lane

14 FATHER'S NAME

Howard

MIDDLE

Hubbard

LAST

15 MOTHER'S MAIDEN NAME

Dorothy

MIDDLE

Lipscomb

LAST

16a WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b SOCIAL SECURITY NO.

219-05-0676

17 INFORMANT

Preston Green

ADDRESS

822 E. Coldspring Lane

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b) ADVANCED METASTATIC DISEASE

DUE TO, OR AS A CONSEQUENCE OF

(c) S.P. CA. (R) BREASTAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ AT WORK  
AT WORK ☐21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. certify that (I) (this hospital) attended the deceased from JUNE 27 19 79 to JUNE 27 19 79, that (I) (we) lost  
saw the deceased alive on JUNE 27 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING  
PHYSICIAN ☐MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☒

22c. DATE SIGNED

6-27-79.

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

MOHAMMAD A. JABBAR

22e. ADDRESS

2724 N.C. ST. BALTO. MD. 21218

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

6/30/79

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cem.

23d. LOCATION  
CITY OR TOWN

Anne Arundel Co., Md.

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME

Wm C March F/H

ADDRESS

1101 E. North Ave.

25a. DATE REC'D. BY REGISTRAR

JUN 29 1979

25b. REGISTRAR'S SIGNATURE

L. J. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

28

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

14186

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	MIN.
James				Green	6		22	79		3	P
3 SEX	M	4 RACE	B	5 DATE OF BIRTH	7		15	67	6 AGE (IN YEARS LAST BIRTHDAY)		71
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		Baltimore MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		Retired			
13a STATE		13b CITY OR TOWN		13c STREET ADDRESS		1922 Harry Weiss Ct City 21237					
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
Unknown		Unknown		019-18-9403		Best Records		4940 Eastern Ave.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 514- Ventricular Tachycardia DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6/22/79 6/22/79	
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 6/22, 19 79, to 6/22, 19 79, that (I) (we) last saw the deceased alive on 6/22/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED	
22b SIGNATURE P. Fishman		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED		6/22/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Paul Fishman				Removal		6/27/79					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE		25b. REG. NO.		25c. REG. NO.		25d. REG. NO.	
Anatomy Board		Balto., Md.		JUL 3 1979							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14187

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Dr. Lewis</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 4-79</b>			2b. HOUR <b>8<sup>45</sup> A.M.</b>		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>July 15, 1884</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			8. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto City</b> MD			10. CITY OR TOWN OF DEATH <b>Balto</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hosp.</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chiropodist</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>			13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		
13b. COUNTY <b>—</b>			13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>8 E. Pleasant Street</b>			14. FATHER'S NAME FIRST MIDDLE LAST <b>Lewis H. Green</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>McCabe</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>213-34-2420</b>			17. INFORMANT ADDRESS <b>Mrs. Alpha Williams-1805 Gwynns Falls Pky.</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>2765</b> IMMEDIATE CAUSE (a) <b>ACUTE RENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERE DEHYDRATION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5/23 1979</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>301 ST. PAUL PL BALTO MD 21202</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>5/23 1979</b> to <b>6/4 1979</b> , that (I) (we) last saw the deceased alive on <b>6/4 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Stephen K. Dyal</b> DEGREE <b>MD</b>						22c. DATE SIGNED <b>6/4/79</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEPHEN DYAL</b>
22e. ADDRESS <b>301 ST. PAUL PL BALTO MD 21202</b>						23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		
23b. DATE <b>June 7, 1979</b>			23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>H. Sander &amp; Sons, Inc. Baltimore, Md. 21213</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 14 1979</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14188

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MELVIN GREEN</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 26 1979</b>			2b. HOUR <b>8:18 a.m.</b>		
3. SEX <b>male</b>	4. RACE <b>negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2-23-24 55 YRS.</b>	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 26 1979</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>912 N. Rutland Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Disabled</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>912 Rutland Ave.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Collins</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie Green</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>251-22-2325</b>		17. INFORMANT ADDRESS <b>Minnie Vandorst 912 Rutland Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>[Signature]</i>			TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>6-26-79</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>			ADDRESS <b>111 Penn St.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>6-30-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Calvin B. Scruggs Sr.</b>			ADDRESS <b>1412 E. Preston</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 27 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

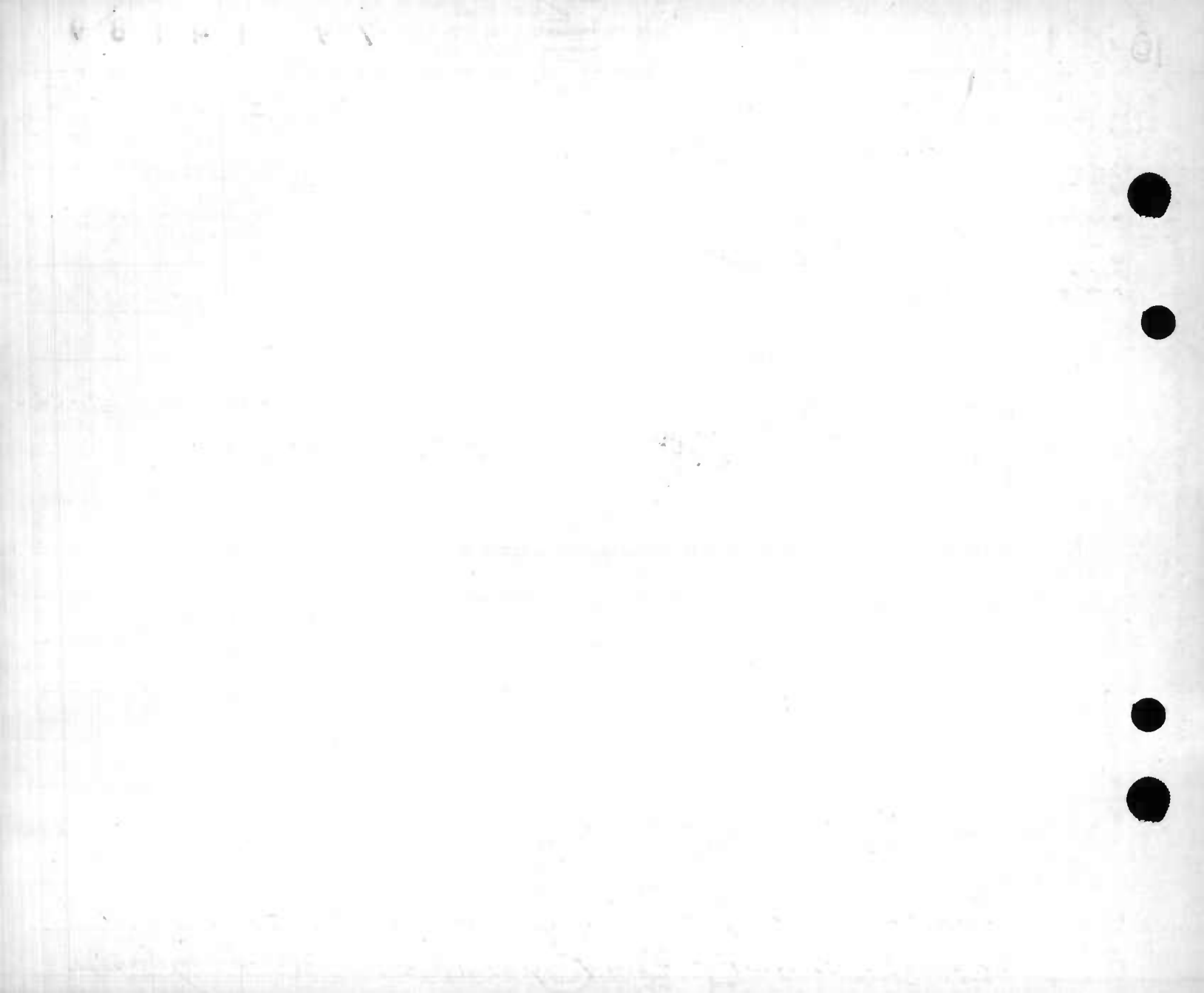
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DOROTHA W. GREEN			2a. DATE OF DEATH MONTH DAY YEAR 6 9 79			2b. HOUR 2:00 AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 3 43		6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LOUISIANA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MD - BCR				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse	
13a. STATE MD		13b. COUNTY		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 4915-A-8 CHALLEDON	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Williams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Cooley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 439-74-7769		17. INFORMANT ADDRESS Nicholas W. Green 4515 Challedon			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma 1749 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 5/16/79 to 6/5/79, that (I) (we) lost saw the deceased alive on 6/5/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22a. SIGNATURE Steven Steinberg MD		22b. DATE SIGNED 6/5/79	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN STEINBERG		22d. ADDRESS BALTO. Cancer Research Center U. of MD Hosp	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/11/79		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Md.	
24. FUNERAL DIRECTOR NAME Charles L. Glover F.H.				25. DATE REC'D. BY REGISTRAR JUN 5 1979		25b. REGISTRAR'S SIGNATURE H. H. H. H.	
ADDRESS 4204 Ridgewood Ave							



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Virginia E. GREEZICKI</b>		2a DATE OF DEATH MONTH DAY YEAR <b>June 20, 1979</b>		2b HOUR <b>1:00 PM</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Aug. 14, 1919</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>59 YRS</b>	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3118 Harford Road</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a STATE <b>Maryland</b>		13b CITY OR TOWN <b>Baltimore</b>		13c STREET ADDRESS <b>3118 Harford Road</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Harry Staton</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Bradfield</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>215-10-5649</b>		17 INFORMANT ADDRESS <b>21218 John H. Greezicki 3118 Harford Rd.</b>	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>coronary occlusion, acute</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>advanced sclerotic vessel disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1-2 min</b> <b>hours</b> <b>decade</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  
**Chronic lung insufficiency**

19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>many years</b> 19 <b>—</b> to <b>July</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>—</b> 19 <b>—</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Dan McDougal</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6/21/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAN MCDUGAL</b>		22e. ADDRESS <b>300 E. Joppa Rd. Towson</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 23, '79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park Baltimore Co. Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>William E. Johnson</b>		ADDRESS <b>8521 Loch Raven Blvd</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 are retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Handwritten signature

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

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REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) OTTO JOHN GREUL			2a. DATE OF DEATH MONTH DAY YEAR JUNE 20, 1979		2b. HOUR M
3 SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR SEPT. 12, 1918		6 AGE (IN YEARS LAST BIRTHDAY) 60	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.		
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5309 WENDLEY RD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POLICE OFFICER		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD			13b. COUNTY BALTO.	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST OTTO JOSEPH GREUL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES MARY TRABERT.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) LWWII 220-03-2985		17 INFORMANT ADDRESS 2113 APT. F. FRIEDA GREUL TOWNHILL RD	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4140 Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) ASD DUE TO, OR AS A CONSEQUENCE OF (c) Approximate Interval Between Onset and Death 3 and months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9pm, 19 70 to 6/20, 19 79, that (I) (we) lost saw the deceased alive on 3/20, 19 79 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE James Nolan MD		DEGREE		22c. DATE SIGNED 6/22/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NOLAN JJ		22e. ADDRESS 1 Mallow Hill Rd # 21229 Balt			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-23-79	23c. NAME OF CEMETERY OR CREMATORY PARKWOOD		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.
24 FUNERAL DIRECTOR NAME WEBER FUNERAL HOME		ADDRESS 5311 EDMONDSON		25a. DATE REC'D. BY REGISTRAR JUN 26 1979	
				25b. REGISTRAR'S SIGNATURE Hickey/ReBrady	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL: ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 1 4 1 9 2						
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE</b>			FIRST <b>GEORGE</b>			MIDDLE <b>GRIEFF</b>			LAST <b>GRIEFF</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 13 79</b>		2b. HOUR <b>3:45 P.M.</b>		
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>XX XX XX</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>68 XXX</b>			7. IF UNDER 1 YEAR MONTHS DAYS <b>XXX</b>		8. IF UNDER 24 HRS HOURS MIN. <b>XXX</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b>			10. MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN HOSPITAL, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UNEMPLOYED</b>			12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (IF IN HOSPITAL, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>4830 WILKENS AVENUE</b>			13f. #21223	
14. FATHER'S NAME FIRST <b>MAX</b>			MIDDLE <b>GRIEFF</b>			LAST <b>GRIEFF</b>			15. MOTHER'S MAIDEN NAME FIRST <b>IDA</b>			MIDDLE <b>SHAPIRO</b>			LAST <b>SHAPIRO</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>215-05-6324A</b>			17. INFORMANT <b>MRS. SANDRA KURFZ</b>			17. ADDRESS <b>707 ELM RD., ARBUTUS, MD 21227</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory arrest</b> <b>1951</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Ca of Lung, from</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Chest wall Ca</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22. I certify that (I) (this hospital) attended the deceased from <b>6.7</b> , 19 <b>79</b> , to <b>6.13</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6.13</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22a. SIGNATURE <b>A. Leonard</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>6/13/79</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. LEONARD</b>			22e. ADDRESS <b>ST AGNES HOSPITAL BALTO., MD</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>JUNE 15, 1979</b>			23c. NAME OF CEMETERY OR CREMATORY <b>WORKMEN CIRCLE</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>							
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>			ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 14 1979</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 60M 1/75  
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) <b>JOHN A. GRIMES</b>		2a. DATE OF DEATH MONTH <b>6</b> DAY <b>4</b> YEAR <b>79</b>		2b. HOUR <b>7:27 P.M.</b>			
3 SEX <b>male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>18</b> YEAR <b>10</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>68</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>CITY Baltimore MD.</b>			
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTO. CITY HOSP.</b>		11a. INVENTOR OF DEATH (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Management</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Paint</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b> COUNTY <b>Baltimore</b>		13b. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2010 Searles Road</b>			
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Harrison</b> LAST <b>Grimes</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Ella</b> MIDDLE <b>Smith</b> LAST <b>Smith</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-10-6778</b>		17. INFORMANT ADDRESS <b>2010 Searles Rd. Balto. MD 21222</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>410 -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>G. Weener MD</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/4</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. Weener MD</b>		22e. ADDRESS <b>BALTO. CITY HOSP.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/8/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie MD</b>			
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc</b> ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia Kelly</b>			

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14194	
1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) <b>HOWARD GROSS</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6 25 19 79		2b. HOUR <b>M</b>	
3 SEX <b>male</b>		4 RACE <b>negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 21 52</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>26 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (CITY AND STATE) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2574 Druid Park Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard Dennis Gross</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eleanora Baker</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Richard Gross 2574 Druid Park Dr.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple visceral and skeletal injuries</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>6:15 P.M. 6-25- 19 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Pedestrian struck by auto.</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>road</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Coldspring Lane East Balto. Md.</b> <b>of Old York Rd.</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>		TITLE (SPECIFY) <b>Assistant</b>						DATE SIGNED <b>6-26-79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>		ADDRESS <b>111 Penn St.</b>									
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>6/30/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>William C. Brown</b>		ADDRESS <b>1206-08 West North Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



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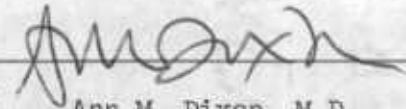
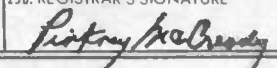
DATE: [illegible]

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REMARKS: [illegible]

Items #18a-22a Film 6533 7/2/79 rc STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14195

1. DECEASED NAME (TYPE OR PRINT) <b>THOMAS L. GROSS</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 1 1979</b>			2b. HOUR M <b>9:04</b> P M		
3. SEX <b>male</b>	4. RACE <b>negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 2 55</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>23</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 1 1979</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5426 Sarril Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>818 W. North Ave.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Gross</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Olif Tillett</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-64-7459</b>		17. INFORMANT ADDRESS <b>Emily Bailey 818 W. North Ave.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Methadone intoxication</b> <b>3040</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER					DATE SIGNED <b>6-2-79</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>		ADDRESS <b>111 Penn St.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/5/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Oak Grove Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elizabeth City, N.C.</b>		
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 5 1979</b>		25b. REGISTRAR'S SIGNATURE 

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

29144-45

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROMAN J GUERCIO			2a. DATE OF DEATH MONTH DAY YEAR JUNE 4, 1979		2b. HOUR 4:45 AM	
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 10, 1958		
6 AGE (IN YEARS LAST BIRTHDAY) 20 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hess Gas Station Attendant		
12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY AA		13c. CITY OR TOWN Odenton		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1458 Berger Street				
14 FATHER'S NAME FIRST MIDDLE LAST Roman A. Guercio			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jean Williamson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS Mrs. Jean Guercio, Mother, same as 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> 2050 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>AML</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>June 3, 1979</u> to <u>June 4, 1979</u> , that (I) (we) last saw the deceased alive on <u>June 4, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Frank L. Douglas M.D.</u>		DEGREE		22c. DATE SIGNED <u>6/4/79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Frank L. Douglas</u>		22e. ADDRESS <u>Johns Hopkins Hospital, Dept. of Medicine</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>6/7/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge</u>		
23d. LOCATION CITY OR TOWN COUNTY STATE						
24. FUNERAL DIRECTOR NAME <u>James S. Kirkley, Glen Burnie, Md.</u>				25a. DATE REC'D. BY REGISTRAR <u>JUN 5 1979</u>		
				25b. REGISTRAR'S SIGNATURE <u>Patricia McCreedy</u>		

BP

DHMH-16 20M  
(VRA 15, 4) 7/78

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR - STATE REGISTRAR		7 9 1 4 1 9 7		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Willard</b> <del>XXXXXXX</del> <b>I</b> <del>XXXXXX</del> <b>Gulley</b>				2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
3. SEX <b>Male</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
				5 25 03		75 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>	
13a. STATE <b>Md</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wade</b> <b>Gulley</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Flora</b> <b>McIntyre</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS <b>Wallace H. Manning 916 Rosedale Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> <b>4275</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>S/P Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>4/18</b> , 19 <b>79</b> , to <b>5/10/79</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>5/10</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Simon I. Bardin</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>5/10/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Simon Bardin</b>				22e. ADDRESS <b>BCH</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/14/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salem W. Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Walter Dabrowski</b>				ADDRESS <b>1005 Dundalk Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry Dabrowski</b>	

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Walter Dabrowski



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CATHERINE M. GULLIVAN			2a. DATE OF DEATH MONTH DAY YEAR June 2, 1979			2b. HOUR M				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sep. 2, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland			13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4119 Shannon Drive 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Hejl					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS 205 Sipple Avenue Robert Gullivan (son) 21236					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YRS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Dementia, Parkinsonism</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/25/69</u> , 19 <u>  </u> , to <u>6/2/79</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>5/22/79</u> , 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>[Signature]</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/5/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. M. Friedman, M.D.					22e. ADDRESS 5211 Harford Road					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/6/79		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR'S NAME Schumaker Funeral Home, Inc.			24b. ADDRESS 3331 Brehms Lane Balto. Md. 21213			25a. DATE REC'D. BY REGISTRAR JUN 5 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The low requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNITED STATES  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Pages 3 and 4 should be filled in by the funeral director. Pages 5 and 6 should be filled in by the funeral director. Pages 7 and 8 should be filled in by the funeral director. Pages 9 and 10 should be filled in by the funeral director. Pages 11 and 12 should be filled in by the funeral director. Pages 13 and 14 should be filled in by the funeral director. Pages 15 and 16 should be filled in by the funeral director. Pages 17 and 18 should be filled in by the funeral director. Pages 19 and 20 should be filled in by the funeral director. Pages 21 and 22 should be filled in by the funeral director. Pages 23 and 24 should be filled in by the funeral director. Pages 25 and 26 should be filled in by the funeral director. Pages 27 and 28 should be filled in by the funeral director. Pages 29 and 30 should be filled in by the funeral director. Pages 31 and 32 should be filled in by the funeral director. Pages 33 and 34 should be filled in by the funeral director. Pages 35 and 36 should be filled in by the funeral director. Pages 37 and 38 should be filled in by the funeral director. Pages 39 and 40 should be filled in by the funeral director. Pages 41 and 42 should be filled in by the funeral director. Pages 43 and 44 should be filled in by the funeral director. Pages 45 and 46 should be filled in by the funeral director. Pages 47 and 48 should be filled in by the funeral director. Pages 49 and 50 should be filled in by the funeral director. Pages 51 and 52 should be filled in by the funeral director. Pages 53 and 54 should be filled in by the funeral director. Pages 55 and 56 should be filled in by the funeral director. Pages 57 and 58 should be filled in by the funeral director. Pages 59 and 60 should be filled in by the funeral director. Pages 61 and 62 should be filled in by the funeral director. Pages 63 and 64 should be filled in by the funeral director. Pages 65 and 66 should be filled in by the funeral director. Pages 67 and 68 should be filled in by the funeral director. Pages 69 and 70 should be filled in by the funeral director. Pages 71 and 72 should be filled in by the funeral director. Pages 73 and 74 should be filled in by the funeral director. Pages 75 and 76 should be filled in by the funeral director. Pages 77 and 78 should be filled in by the funeral director. Pages 79 and 80 should be filled in by the funeral director. Pages 81 and 82 should be filled in by the funeral director. Pages 83 and 84 should be filled in by the funeral director. Pages 85 and 86 should be filled in by the funeral director. Pages 87 and 88 should be filled in by the funeral director. Pages 89 and 90 should be filled in by the funeral director. Pages 91 and 92 should be filled in by the funeral director. Pages 93 and 94 should be filled in by the funeral director. Pages 95 and 96 should be filled in by the funeral director. Pages 97 and 98 should be filled in by the funeral director. Pages 99 and 100 should be filled in by the funeral director.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
DONALD JOSEPH GUNTER		M Male		White W		MONTH DAY YEAR 12 30 22		56 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF MOST OF LIFE)	
Maryland		U.S.A.				Baltimore City		Electrical Engineer B.G. & E.	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Baltimore		Church Home and Hospital		Maryland				Baltimore	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Joseph		Gladys		Yes		216-18-3856		Carol A. Gunter 4816 Greencrest Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. DUE TO, OR AS A CONSEQUENCE OF (b)		20. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
5712 CARDIAC ARREST		HEPATO RENAL FAILURE		LAENNE'S CIRRHOSIS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Sompalli Prasad									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Sompalli Prasad									
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
Burial		July 2, 1979		Parkwood		Baltimore		Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Leonard J. Ruck, Inc. Baltimore, Maryland		JUL 2 1979		Dorothy McBrady					

MEDICAL CERTIFICATION

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THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 9 14200	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
		IDA		Guthoff		June 23 1979		605 A.M.			
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		WHITE		Dec. 25 1992		86					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
BAL To. Md.		United States				BAL To. CITY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BAL TImore		Levinthal-Hebrew-Germanic Hos.		Sales Arison		RETAIL					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		#21207	
Md.		BAL To.		BAL To.				3301 Greenmeade Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		(21207)	
ABRAHAM S HANKIN		SARAH ESTHER UNKNOWN		No		277-147839		MRS. SHIRLEY SHAVITZ		3301 GREENMEADERD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> 7070 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Multiple Decubiti</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Months</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6/23/79</u> , 19 <u>79</u> , to <u>6/23/79</u> , 19 <u>79</u> , that (we) lost the deceased alive on <u>6/23/79</u> , 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DEGREE		22d. DATE SIGNED							
Joseph J. Zerman		MD		6/23/79							
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS									
JOSEPH GERMAN		Sinai Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		6/24/79		ANSHE NEISEN		ROSEDALE MD.					
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE					
SOL LEVINSON & BROS		6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)		JUN 27 1979		P. J. McBrady					

MEDICAL CERTIFICATION

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U.S.A.

V.V.

1. The first part of the paper is devoted to a general survey of the situation in the field of research on the structure of the atomic nucleus. It is shown that the present state of knowledge is such that it is necessary to consider the possibility of the existence of a new type of nuclear structure, namely, the so-called "superheavy" nuclei. These nuclei are characterized by a very high atomic number and a very high mass, and they are supposed to be stable against alpha and beta decay. The existence of such nuclei would have important consequences for the theory of the strong interaction and for the understanding of the origin of the elements.

2. In the second part of the paper, the author discusses the results of the experiments carried out in the U.S.S.R. and in the U.S.A. on the synthesis of superheavy nuclei. It is shown that the results of these experiments are in good agreement with the predictions of the theory. The author also discusses the results of the experiments on the decay of superheavy nuclei, and shows that these results are also in good agreement with the theory. The author concludes that the existence of superheavy nuclei is a fact, and that they are stable against alpha and beta decay.

CHINESE IN AMERICA



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 9 14201			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DORIS M. GUTHRIDGE				2b. HOUR 1:45 PM			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 3/27/11		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.	
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSEW		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY BALTO 13c. CITY OR TOWN SPARROWS PT.				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 26 A SHORE RD	
14. FATHER'S NAME FIRST MIDDLE LAST JACOB R. RUHLAND				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE LOWMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. UNK		17. INFORMANT ADDRESS GEORGE A. GUTHRIDGE SR. ABOLIE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 5354 } DUE TO, OR AS A CONSEQUENCE OF (b) BILATERAL PNEUMONIA (c) SEPTIC SHOCK DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) PROBABLE ANASTOMOTIC LEAK							
19a. DATE OF OPERATION 5-25-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SEVERE ALKALINE BILE		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) GASTRITIS			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that this hospital attended the deceased from 5/13/1979 to 6/6/1979, that I saw the deceased alive on 6/6/1979, and that in my opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, we lost view of the body after death.)							
22b. SIGNATURE G. Guruswamy MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/6/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GOPAL GURUSWAMY MD		22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTIMORE, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/9/79		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD	
24. FUNERAL DIRECTOR NAME J.G. CONNELLY				ADDRESS 300 MAC		25a. DATE REC'D. BY REGISTRAR JUN 11 1979	
				25b. REGISTRAR'S SIGNATURE L. H. McCready			



10254

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 14202

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Anthony Francis Gutowski		Male		Caucasian	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
Jan 1, 1920		59 YRS		Balto. City MD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
MD		USA			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Balto. City		USPHS Hospital		seaman	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MD				Balto	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
John Gutowski		Helen Dombroski		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
213 14 0689		Records-		USPHS Hospital	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cardiovascular shock					30 MIN
1991 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic carcinoma					TERMINAL
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May, 25 1979, to June 5, 1979, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on June 5, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
D.F. Bowman MD				6/5/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
D.F. Bowman		3100 Wyman Park Drive			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		6/8/79		ST. STANISLAUS	
24. FUNERAL DIRECTOR		24b. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		JUN 8 1979		History Melindy	
GEORGE A. WEBER & Sons Inc - 705 S. Ann St.					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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June 8, 1979

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Jan 1, 1980

Canadian

Male

Balto. City

USA

MD

USPHS Hospital

Balto. City

Seaman

1808 Lancaster St

Balto

MD

213 14 0668 Records - USPHS Hospital

MD

June 8, 1979

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May 28, 1979

June 8

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 9 1 4 2 0 3	
1- FOR STATE REGISTRAR						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTIN J. GUTOWSKI SR.						6/24/79				M	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11/22/07		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.					
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. CITY HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LONG SHOREMAN		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD						13b. COUNTY BALTO		13c. CITY OR TOWN DUNDALK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST STANLEY GUTOWSKI						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA VAK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 01 8947		17. INFORMANT ADDRESS JEANETTE GUTOWSKI ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>H. &amp; A. S. C. V. D. &amp; Cardiac Arrhythmia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Severe C.O. P.D.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>Years</u> <u>Years.</u>										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>NOV.</u> 19 <u>72</u> , to <u>June</u> 19 <u>79</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>June 14</u> 19 <u>79</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) did not view the body after death.											
22b. SIGNATURE <u>Ataollah Golpira</u>				DEGREE MD. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/25/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ATAOLLAH GOLPIRA				22e. ADDRESS 3029 Dundalk Ave. Balto, Md. 21222							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/24/79		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD					
24. FUNERAL DIRECTOR NAME J. G. CONNELLY				ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR JUL 5 1979		25b. REGISTRAR'S SIGNATURE <u>Robert M. Brady</u>			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Their license requires carbon copies. Pages 1 and 2 should be filed within 72 hours of burial with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 1 4 2 0 4	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DR WILLIAM EDWARD HAHN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6/21/79</b>		2b. HOUR <b>10:50 P M</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 5 05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dentist</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Catonsville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph H. Hahn</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Meyers</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-24-3165</b>		17. INFORMANT ADDRESS <b>Mrs. Margaret V. Hahn Same as # 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma, Lungs, heart</b> <b>185-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>hilar lymph nodes, Adrenals</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Carcinoma of the prostate</b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6/10, 19 79</b> , to <b>6/21, 19 79</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>6/21, 19 79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE <b>Joan E. Whitehouse</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6/22/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOAN E. WHITEHOUSE M.D.</b>		22e. ADDRESS <b>ST Agnes Hosp. 900 Caton Ave. Balt. 21227</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/25/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley Cemetery Westminster Md.</b>	
23d. LOCATION CITY OR TOWN <b>Catonsville</b>		COUNTY <b>Carroll</b>		STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>MacNabb Funeral Home</b>		ADDRESS <b>Catonsville, Md. 21228</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 25 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79 14205 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Joanne STRATTON Haines</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>June 8, 1979</b>				2b. HOUR <b>7:45p M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCT. 12, 1948</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>30</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Exec. Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
13a. STATE <b>Penna.</b>		13b. COUNTY <b>Lancaster</b>		13c. CITY OR TOWN <b>Lancaster</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>562 Greenland Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest V. Haines</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth Hayes</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>147-38-3783</b>		17. INFORMANT ADDRESS <b>Ernest V. Haines 128 Mountain View Rd. Warren, N.J. 07060</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Neurological Event</b> 2500 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes, Hypertension, Renal Failure Many Yrs.</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>6/1/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Chronic Renal Failure</b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6/8</b> 19 <b>79</b> to <b>6/8</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/8</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>James F. Burdick</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/8/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James F. Burdick</b>				22e. ADDRESS <b>Dept. Surg., JH H</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 12, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION CITY OR TOWN <b>Brentwood, Prince Georges</b>		COUNTY STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc.</b>				ADDRESS <b>6500 York Rd. Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100) (101) (102) (103) (104) (105) (106) (107) (108) (109) (110) (111) (112) (113) (114) (115) (116) (117) (118) (119) (120) (121) (122) (123) (124) (125) (126) (127) (128) (129) (130) (131) (132) (133) (134) (135) (136) (137) (138) (139) (140) (141) (142) (143) (144) (145) (146) (147) (148) (149) (150) (151) (152) (153) (154) (155) (156) (157) (158) (159) (160) (161) (162) (163) (164) (165) (166) (167) (168) (169) (170) (171) (172) (173) (174) (175) (176) (177) (178) (179) (180) (181) (182) (183) 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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14206

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Dennis J. Hall</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 9 1979</b>			2b. HOUR <b>4:51 AM</b>		
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 20 53</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>25 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 9 1979</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital (STU)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1300 Longwood St.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Cornelius Hall</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary L. Johnson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>unknown</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mary L. Hall 1300 Longwood St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun Wound of Head and Chest</b> <b>9654</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8:20xx 6 9 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject shot by police</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>car</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Music Fair Lane Baltimore Md.</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Margie McNeill</i>			TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>6/9/79</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>			ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/12/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>WM. C. MARCH F/H</b>			ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Robert McCreedy</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR			7 9 1 4 2 0 7 REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		
John			Hall						June 3 1979		9:25 p.m.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		Caucasian		10-2-28 1912				69 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
								Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)											
Baltimore		Church Home Hospital											
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Md.		---		Baltimore				1710 Aliceanna St.					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT				ADDRESS					
		911-20-3594											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ENCEPHALOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>BI-LATERAL PNEUMONIA</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 16</u> , 19 <u>79</u> , to <u>JUNE 3</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>JUNE 3</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)													
22b. SIGNATURE <i>Paul E. Gormley</i>				DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>6/21/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul E. Gormley, M.D.				22e. ADDRESS Church Hospital Corp. 100 N. Broadway, Baltimore, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Removal		6-13-79											
24. FUNERAL DIRECTOR NAME Anatomy Board of Md.				ADDRESS Baltimore, Md.				25a. DATE REC'D. BY REGISTRAR JUN 28 1979		25b. REGISTRAR'S SIGNATURE <i>Robert Gormley</i>			

10541 81

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

NAME	LAST	FIRST	MIDDLE	SUFFIX
DATE OF BIRTH				
PLACE OF BIRTH				
CITY				
STATE				
COUNTRY				
EDUCATION				
EMPLOYMENT				
RESIDENCE				
TELEPHONE				
RELIGION				
POLITICAL AFFILIATION				
CRIMINAL RECORD				
REMARKS				

FBI 81 1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH - 16 25M

(VR A 15 (4) 9/74)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 2 0 8

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KATHLEEN N. HALL			2a. DATE OF DEATH MONTH DAY YEAR JUNE 2 '79		2b. HOUR 3:20 A.M.
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR MAY 16 79	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 16		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.		
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY 13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 5111 Goodbow Road Apt. C	
14. FATHER'S NAME FIRST MIDDLE LAST ITAL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATH WANDA HALL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> 7479 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>RESPIRATORY FAILURE</u> (c) <u>PERSISTENT FETAL CIRCULATION</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HYDROCEPHALUS LARGE FONTANELLE DEFECTIVE NASAL CARTILAGE, CLEFT PALATE, MALROTATION INTESTINE					
19a. DATE OF OPERATION 5/16/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Omphalocele		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from May 16, 19 79, to June 2, 19 79, that (I) (we) lost saw the deceased alive on JUNE 2, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. Koehler MD		DEGREE		22c. DATE SIGNED 6/2/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. KOEHLER		22e. ADDRESS UNIV. HOSP			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/4/79	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H		ADDRESS 11101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 5 1979	25b. REGISTRAR'S SIGNATURE Rickey McCreedy

BP



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20% COTTON

2000 0000 0000 0000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 2 0 9

1. DECEASED NAME (TYPE OR PRINT) <b>Hollowell, Esther, SARAH HOLLOWELL -HALLOWELL</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 28 1979</b>		2b. HOUR <b>1:00 P.M.</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10-18-01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>(77) 77 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CHURCH Hospital Corp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>
13a. STATE <b>Baltimore</b>			13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM HOSFELD</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSANNE KELLY</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-09-3867</b>		17. INFORMANT ADDRESS <b>PATRICIA MCGING 9215 OLDHAM ST. BALTO. 21224, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE <b>METASTATIC CARCINOMA ?</b> (b) <b>metastatic Carcinoma</b> DUE TO, OR AS A CONSEQUENCE <b>ENCEPHALOPATHY</b> (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 3, 1979</b> , to <b>JUNE 28, 1979</b> , that (I) (we) (most) saw the deceased alive on <b>JUNE 28, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Karkar</b>		DEGREE		22c. DATE SIGNED <b>6-28-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE KARKAR, M.D.</b>		22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTIMORE, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7-2-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>DAK LAWN CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>7225 EASTERN BLVD, BA, Co., MD.</b>
24. FUNERAL DIRECTOR NAME <b>Charles A. Zuber &amp; Son, Inc.</b>		ADDRESS <b>9015 CONKLING ST. BALTO, 21224, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 5 1979</b>	25b. REGISTRAR'S SIGNATURE <b>Patricia McGing</b>

MEDICAL CERTIFICATION

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POST 1

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

10-10-10



TO THE DIRECTOR, BUREAU OF LAND MANAGEMENT  
FROM THE ASSISTANT DIRECTOR, BUREAU OF LAND MANAGEMENT

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

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[Illegible]

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[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1 - STATE REGISTRAR				7 9 1 4 2 1 0 REG. NO.							
1 DECEASED NAME (TYPE OR PRINT) <i>Sarah</i>				FIRST <i>Hamilton</i>				2a. DATE OF DEATH MONTH <i>6</i> DAY <i>21</i> YEAR <i>79</i>		2b. HOUR <i>2:30 A.M.</i>	
3 SEX <i>Female</i>		4 RACE <i>Black</i>		5. DATE OF BIRTH MONTH <i>12</i> DAY <i>11</i> YEAR <i>23</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>55</i> YRS		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN <i></i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ba 40</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Ba 40</i> MD.					
10 CITY OR TOWN OF DEATH <i>Ba 40</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>At Home - 2135 Druid Hill Ave</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING HRS) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md</i>		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>2135 Druid Hill Ave</i>			
14. FATHER'S NAME FIRST <i>Thos.</i> MIDDLE <i>E.</i> LAST <i>Johnson</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Constance</i> MIDDLE <i>Smith</i> LAST <i>Smith</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO <i>UNK</i>		17 INFORMANT <i>Geo Hamilton - 2135 Druid Hill Ave</i> ADDRESS							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>4639</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Atherosclerotic cardiovascular disease</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER!)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive or above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>J. H. Sadler MD</i> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>6/21/79</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. H. Sadler MD</i>				22e. ADDRESS <i>Univ. Md. Hospital</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6-25-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>At Amburn</i>		23d. LOCATION CITY OR TOWN <i>Ba 40</i> COUNTY STATE <i>Md</i>					
24. FUNERAL DIRECTOR NAME <i>Powell F H</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 29 1979</i>				25b. REGISTRAR'S SIGNATURE <i>Anthony Keady</i>			

01241-9

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

14211

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HARRY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-18-79</b>			2b. HOUR <b>10<sup>15</sup></b> AM			
3 SEX <b>MALE</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>DEC. 12, 1904</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD			
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESMAN</b>		12b KIND OF BUSINESS OR INDUSTRY <b>GEN. MDSE.</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>#21215 3601 FORDS LA., APT. 219</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>MARCUS HANDLEMAN</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MANYA UNKNOWN</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-22-7437</b>		17 INFORMANT <b>HEBREW BURIAL &amp; SOCIAL SER. SOC.</b> <b>1330 REISTERSTOWN RD. BALTO., MD 21208</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>5789</b> IMMEDIATE CAUSE (a) <b>Renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>upper GI bleeding</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>2 toks</b> <b>1 toks</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION <b>6-6-79</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>fair</b>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>6-3</b> , 19 <b>79</b> , to <b>6-18</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6-18</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Aug 10. Cron</b>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED <b>6-18-79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>SARA H. CRON, M.D.</b>				22e ADDRESS <b>Sinai Hosp. of Baltimore</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>JUNE 19, 1979</b>		23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>			
24 FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> NAME ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>						25a DATE REC'D. BY REGISTRAR <b>JUN 22 1979</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHFOR  
1 - STATE  
REGISTRAR

REG. NO.

1 4 2 1 2

1. DECEASED NAME (TYPE OR PRINT) <b>Lottie P. Happie</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 26, 1979</b>			2b. HOUR <b>P.</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 1, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Louisville, Ky.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Home Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Factory Worker-Tobacco Co.</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>			13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>103 N. Glover Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Land</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Idea Spellman</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>406-10-0970</b>		17. INFORMANT <b>Mrs. Virginia P. Hrubec</b>				17b. ADDRESS <b>103 N. Glover Street-Balto., Md. 21224.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured Abdominal aneurysm</b> 4413 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis - Abd aorta</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Severe emphysema</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>6/26</b> 19 <b>77</b> , to <b>6/27</b> 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>6/26</b> 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Morton C. Orman</b>					DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/27/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MORTON C ORMAN</b>					22e. ADDRESS <b>2936 E BALTIMORE ST</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/30/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenville Cemetery-Greenville, Indiana</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>John A. Moran, Inc.</b>					ADDRESS <b>3000 E. Baltimore St.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 2 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Nov. 1, 1900

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14213	
1. DECEASED NAME (TYPE OR PRINT) <b>Isaac Hardy</b>						2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/> <b>6 10 19 79</b>		2b. HOUR <b>M</b>			
3. SEX <b>male</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 01 1906 72</b>	6. AGE (IN YEARS) YRS. <b>72</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD <b>6 10 19 79</b>		7d. HOUR <b>12: Noon</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Auto Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employ</b>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2415 Calverton Heights Ave</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Isaac Hardy</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LIZZIE Frazier</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-05-1864</b>		17. INFORMANT ADDRESS <b>Mrs. Emily P. Hardy 2415 Calverton Heights Ave.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of chest (Unspecified)</b> 9654 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11:50AM 6/10 19 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>shot by assailant</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>800Blk WhitmoreAve, Balt more, MD</b>							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>		TITLE (SPECIFY) <b>Deputy Chief</b>				DATE SIGNED <b>6/11/79</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>		ADDRESS <b>111 Penn Street, Baltimore, MD</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 15, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, County Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Herbert E. Nutter 3035 W. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Pitney Kelvody</i>					

X



*Handwritten signature or initials.*

*Handwritten text, possibly a date or reference number.*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 14214

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		6		4 79 6:05 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Black		MONTH DAY YEAR		5 31 79		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.				Baltimore City				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Univ. of Md. Hospital									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1520 E. 36th St.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
Roger Carter		Bobbie Hargrove									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
N/A		N/A		Martha Hargrove		1814 E. Belevedere Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)	
7479		7479		7479		7479		7479		7479	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
(b) Persistent Fetal Circulation		(b) Persistent Fetal Circulation		(b) Persistent Fetal Circulation		(b) Persistent Fetal Circulation		(b) Persistent Fetal Circulation		(b) Persistent Fetal Circulation	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
(c)		(c)		(c)		(c)		(c)		(c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from		22a. I certify that (I) (this hospital) attended the deceased from		22a. I certify that (I) (this hospital) attended the deceased from		22a. I certify that (I) (this hospital) attended the deceased from		22a. I certify that (I) (this hospital) attended the deceased from		22a. I certify that (I) (this hospital) attended the deceased from	
5-31, 1979, to 6, 1979, that (I) (we) lost		5-31, 1979, to 6, 1979, that (I) (we) lost		5-31, 1979, to 6, 1979, that (I) (we) lost		5-31, 1979, to 6, 1979, that (I) (we) lost		5-31, 1979, to 6, 1979, that (I) (we) lost		5-31, 1979, to 6, 1979, that (I) (we) lost	
saw the deceased alive on 6/4/79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		saw the deceased alive on 6/4/79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		saw the deceased alive on 6/4/79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		saw the deceased alive on 6/4/79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		saw the deceased alive on 6/4/79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		saw the deceased alive on 6/4/79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE		22b. SIGNATURE		22b. SIGNATURE		22b. SIGNATURE		22b. SIGNATURE		22b. SIGNATURE	
R. Cummings, M.D.		R. Cummings, M.D.		R. Cummings, M.D.		R. Cummings, M.D.		R. Cummings, M.D.		R. Cummings, M.D.	
22c. DATE SIGNED		22c. DATE SIGNED		22c. DATE SIGNED		22c. DATE SIGNED		22c. DATE SIGNED		22c. DATE SIGNED	
6/4/79		6/4/79		6/4/79		6/4/79		6/4/79		6/4/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
R. Cummings, M.D.		R. Cummings, M.D.		R. Cummings, M.D.		R. Cummings, M.D.		R. Cummings, M.D.		R. Cummings, M.D.	
22e. ADDRESS		22e. ADDRESS		22e. ADDRESS		22e. ADDRESS		22e. ADDRESS		22e. ADDRESS	
Univ. of Md. Hospital		Univ. of Md. Hospital		Univ. of Md. Hospital		Univ. of Md. Hospital		Univ. of Md. Hospital		Univ. of Md. Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		6/7/79		Mt. Calvary Cem.		Anne Arundel Co., Md.					
24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR	
NAME		NAME		NAME		NAME		NAME		NAME	
Wm C March F/H		Wm C March F/H		Wm C March F/H		Wm C March F/H		Wm C March F/H		Wm C March F/H	
1101 E. North Ave.		1101 E. North Ave.		1101 E. North Ave.		1101 E. North Ave.		1101 E. North Ave.		1101 E. North Ave.	
25a. DATE REC'D. BY REGISTRAR		25a. DATE REC'D. BY REGISTRAR		25a. DATE REC'D. BY REGISTRAR		25a. DATE REC'D. BY REGISTRAR		25a. DATE REC'D. BY REGISTRAR		25a. DATE REC'D. BY REGISTRAR	
JUN 7 1979		JUN 7 1979		JUN 7 1979		JUN 7 1979		JUN 7 1979		JUN 7 1979	
25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE	
R. Cummings		R. Cummings		R. Cummings		R. Cummings		R. Cummings		R. Cummings	

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POST COTTON BINDER





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14215

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>George G. Hargrove</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6 9 19 79 <input type="checkbox"/> 6 9 19 79			2b. HOUR 6:32 A M		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1-23-1952</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>27</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD <b>6 9 19 79</b>	7d. HOUR <b>6:32</b> A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>113 S. Ann Street</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Roofier</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Roofing</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>233 N. Kenwood Avenue</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Livy Hargrave</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Marie Johnson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>- 1975 240 889 189</b>		17. INFORMANT ADDRESS <b>Ava Gray Hargrave 233 N. Kenwood Ave.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Gunshot Wounds of Head (handgun)</b> <b>9650</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6:05xx 6 9 19 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject shot by assailant</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>house</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>113 S. Ann St., Baltimore Md.</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Margarita A. Korell</b>			TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>6/9/79</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>			ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 13, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Dippel Brothers, Inc.</b>				ADDRESS <b>7110 Belair Rd. 21206</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 11 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Peter H. Brady</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGUERITE A. HARMON						7a. DATE OF DEATH MONTH DAY YEAR 6-11-79		7b. HOUR 3-30 PM	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 9 8 04		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE md.		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1027 CATHEDRAL ST.	
14. FATHER'S NAME FIRST MIDDLE LAST COLEMAN BUTLER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO.			17. INFORMANT MR. ALLEN WILSON			ADDRESS RACLAIR AVE			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2859 Intestinal obstruction DUE TO, OR AS A CONSEQUENCE OF (b) Upper G-I Bleeding DUE TO, OR AS A CONSEQUENCE OF (c) Anemia, Dehydration APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6-7-1979 to 6-11-1979, that (I) (we) lost saw the deceased alive on 6-11-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE B. Narayana				DEGREE M.D.				22c. DATE SIGNED 6-11-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. NARAYANA				22e. ADDRESS Provident Hospital; Baltimore, MD 21205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 6-14-79		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE md.		23e. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 18 1979	
24. FUNERAL DIRECTOR NAME ADDRESS Samuel T. Redd 5209 YORK Rd. BALTO. md.									



REPORT NUMBER

1. TITLE (and Subtitle)

2. AUTHOR (Last Name, First Name, Middle Initial)

3. PERFORMING ORGANIZATION NAME (S)

4. PERFORMING ORGANIZATION REPORT NUMBER

5. MONITORING ORGANIZATION NAME (S)

6. MONITORING ORGANIZATION REPORT NUMBER

7. AUTHORING ORGANIZATION NAME (S)

8. AUTHORING ORGANIZATION REPORT NUMBER

9. PERFORMING ORGANIZATION NAME (S)

10. PERFORMING ORGANIZATION REPORT NUMBER

11. MONITORING ORGANIZATION NAME (S)

12. MONITORING ORGANIZATION REPORT NUMBER

13. AUTHORING ORGANIZATION NAME (S)

14. AUTHORING ORGANIZATION REPORT NUMBER

15. PERFORMING ORGANIZATION NAME (S)

16. PERFORMING ORGANIZATION REPORT NUMBER

17. MONITORING ORGANIZATION NAME (S)

18. MONITORING ORGANIZATION REPORT NUMBER

19. AUTHORING ORGANIZATION NAME (S)

20. AUTHORING ORGANIZATION REPORT NUMBER

21. PERFORMING ORGANIZATION NAME (S)

22. PERFORMING ORGANIZATION REPORT NUMBER

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14217	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Albert Harper</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 10 19 79</b>		2b. HOUR <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6-25-49</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>29</b> YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 10 19 79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>415 E. 22nd St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK) <b>Unemployed</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. IN THE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>3716 Cranston Ave</b>					
14. FATHER'S NAME <b>James Joyner</b>				15. MOTHER'S MAIDEN NAME <b>Sarah Beverly</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-52-8843</b>		17. INFORMANT <b>Sarah Beverly</b>		17. ADDRESS <b>3716 Cranston Ave</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic alcoholism</b> 303- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. PARTIAL YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>				TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGNED <b>6/11/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (S) <b>Burial</b>		23b. DATE <b>6-15-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>				23d. LOCATION <b>Baltimore, Maryland</b> STATE			
24. FUNERAL DIRECTOR <b>Charles L. Glover F. H., 4204 Ridgewood Ave</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Robert H. Hines</i>			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 1 4 2 1 8	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arthur A. Harris			2a. DATE OF DEATH MONTH DAY YEAR 6 9 79			2b. HOUR 1145 AM					
3. SEX Male		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 4 8 28		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore CITY MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor		12b. KIND OF BUSINESS OR INDUSTRY Self Employed			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13. STREET ADDRESS 302 Gwynn Ave.				
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Harris			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Na								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. Korean		17. INFORMANT ADDRESS Mrs. Pauline J. Harris 302 Gwynn Ave.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 431- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intracranial hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypoxia secondary to pulmonary edema or aspiration</u>											
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>6/9</u> 19 <u>79</u> , to <u>6/9</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/9</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Mark J. Kushner M.D.			DEGREE			22c. DATE SIGNED 6/9/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark J. Kushner			22e. ADDRESS University of Maryland Hospital								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 14, 79		23c. NAME OF CEMETERY OR CREMATORY King Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County Md.				
24. FUNERAL DIRECTOR NAME Herbert E. Nutte						ADDRESS 3035 W. North		25a. DATE REC'D. BY REGISTRAR JUN 11 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

61541 2.4





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14219

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES D. HARRISON Jr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 11 79</b>		2b. HOUR <b>10<sup>45</sup> P M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 20, 1926</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>KESWICK NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Banker-Mercantile Deposit</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Safe</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>James D. Harrison</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Green</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 213-28-3387</b>	17. INFORMANT ADDRESS <b>Mrs. Lorna Harrison Same</b>		
18. CAUSE OF DEATH Enter only one cause per line for (1) or (2) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple myeloma</b> 2030 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>May 1, 1979</b> to <b>June 11, 1979</b> , that (1) (we) lost saw the deceased alive on <b>June 11, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>W.B. Daniels, Jr.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6/11/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W.B. Daniels, Jr.</b>		22e. ADDRESS <b>Keswick, 700 W. 40th St. Balto 21211</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-15-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas' Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Garrison Forest, Md.</b>
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b> <b>4905 York Road Balto., Md. 21212</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 14 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. COPIES OF FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14220	
1. DECEASED NAME (TYPE OR PRINT) <b>RANDOLPH HARRY</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR		2b. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR			
3. SEX <b>male</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH <b>7</b> DAY <b>4</b> YEAR <b>53</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>25</b> YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	7c. DATE PRONOUNCED DEAD MONTH <b>6</b> DAY <b>23</b> YEAR <b>1979</b>		7d. HOUR <b>7:35</b> a.m.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Md. General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1311 W. North Ave.</b>			
14. FATHER'S NAME FIRST <b>Mack</b> MIDDLE <b>Harry</b> LAST <b>Harry</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Pearl</b> MIDDLE <b>Williams</b> LAST <b>Williams</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>248-02-2045</b>		17. INFORMANT ADDRESS <b>Lynchburg, S.C.</b> <b>Pearl Harry Star Route Box 71</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple stabwounds of chest</b> 966- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4:25A. 6 23 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>stabbed during altercation</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET <b>1311 W. North Ave.</b> CITY OR TOWN <b>Balto.</b> COUNTY <b>Md.</b> STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Not a cause</b> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>H. R. Guard</i>			M.D. <b>Assistant</b> MEDICAL EXAMINER					DATE SIGNED <b>6/23/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>			ADDRESS <b>111 Penn Street</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/29/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church Cem.</b>		23d. LOCATION CITY OR TOWN <b>Lynchburg, S.C.</b> COUNTY STATE				
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b> ADDRESS <b>1101 E. North Ave.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 23 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Henry McBrady</i>				

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14221

1. DECEASED NAME (TYPE OR PRINT) <b>Seppie E. Hartfield</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 13 79</b>			2b. HOUR <b>M</b>			
3. SEX <b>female</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 14 98</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>80 YRS.</b>	7. IF UNDER 1 YR. MONTHS DAYS <b></b>	7. IF UNDER 24 HRS. HOURS MIN <b></b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 13 1979</b>			2d. HOUR <b>1:48 a.m.</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2006 Barclay Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2006 Barclay St.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Nathan Jordan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>212-14-9658</b>		17. INFORMANT ADDRESS <b>Catherine Beard 2006 Barclay St.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4029 Hypertensive arteriosclerotic cardio vascular disease</b> IMMEDIATE CAUSE (a) <b>4029</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Margarita A. Korell</b>			TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGNED <b>6/13/79</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>			ADDRESS <b>111 Penn Street, Baltimore, MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/19/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>			ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>H. J. [Signature]</b>		

1 5 5 4 1 2 8



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

14222

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LUTHER K. HARTMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 25, 1979.</b>		2b. HOUR <b>M</b>				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 28, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS. MONTHS DAYS		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>509 East 29th. St.</b>			12a. USUAL OCCUPATION (TYPE OF WORK OR LAST OF WORKING LIFE) <b>Sgt. Police Dep't Balto. City</b>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>509 E. 29th Street</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>					
14 FATHER'S NAME <b>William</b> MIDDLE <b>Hartman</b> LAST				15 MOTHER'S MAIDEN NAME FIRST <b>Irene</b> MIDDLE <b>Pipino</b> LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 2</b>		17. INFORMANT ADDRESS <b>Mrs. Beatrice A. Hartman 509 E. 29th Street</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: <b>4912</b> IMMEDIATE CAUSE (a) <b>PULMONARY EMPYSEMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC BRONCHITIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Teodoro Carangal</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/27/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Teodoro Carangal M.D.</b>				22e. ADDRESS <b>824 West 36th. St.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-29-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview</b>		23d. LOCATION <b>Sykesville</b>		COUNTY <b>Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc, 5305 Harford Rd. 21214</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 28 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Robert McBrine</i>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 4 2 2 3			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>IASSIAH HARVEY</b>				2a DATE OF DEATH MONTH <b>6</b> DAY <b>19</b> YEAR <b>79</b>		2b HOUR <b>9:00</b> A.M.	
3 SEX <b>MALE</b>		4 RACE <b>BLACK</b>		5 DATE OF BIRTH MONTH <b>3</b> DAY <b>9</b> YEAR <b>29</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>50</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE, MD.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> MD.	
10 CITY OR TOWN OF DEATH <b>BALTIMORE MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>707 BELGIAN AVE.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SCHOOL BUS DRIVER</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>MARYLAND</b>		13b COUNTY <b>BALTIMORE</b>		13c CITY OR TOWN <b>BALTIMORE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST <b>Bennie</b> MIDDLE <b>HARDY</b> LAST <b>IRENE</b>		15 MOTHER'S MAIDEN NAME FIRST <b>IRENE</b> MIDDLE <b>BOOKER</b> LAST <b>BOOKER</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>219-32-5015</b>		17 INFORMANT <b>Denova Harvey</b> ADDRESS <b>707 BELGIAN AVE.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1520</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Calcium Deposits</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1520</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Kim M Fehr</b> MD		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>6/14/79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kim Fehr</b>		22e ADDRESS <b>Johns Hopkins Hospital</b>		22f <b>Baltimore, MD</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>6-23-79</b>		23c NAME OF CEMETERY OR CREMATORY <b>Arbutus mem. PK</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus MD</b>	
24 FUNERAL DIRECTOR <b>William J. Spicer</b> ADDRESS <b>1639 N. Broadway</b>		25a DATE REC'D. BY REGISTRAR <b>JUN 21 1979</b>		25b REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>			

U.S. - 100 - 100



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14224																									
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST Isaac			MIDDLE Haskins			LAST Sr.			2a. DATE OF DEATH KNOWN OF ESTIMATED			MONTH 6			DAY 12			YEAR 1979			2b. HOUR a.m.								
3. SEX Male			4. RACE Black			5. DATE OF BIRTH MONTH 12			DAY 8			YEAR 21			6. AGE (IN YEARS) (LAST BIRTHDAY) 57 YRS.			IF UNDER 1 YR. MONTHS			IF UNDER 24 HRS. HOURS			MIN.			7c. DATE PRONOUNCED DEAD 6 12 1979			11:50 a.m.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED WIDOWED			NEVER MARRIED			DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.																				
10. CITY OR TOWN OF DEATH Baltimore City			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 851 George St.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																										
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																																			
13a. STATE Md.			13b. COUNTY City			13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 3214 Sequoia Ave																							
14. FATHER'S NAME FIRST Vernon						MIDDLE Haskins						LAST						15. MOTHER'S MAIDEN NAME FIRST Clara						MIDDLE Haskins						LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 11						17. INFORMANT Rosie Haskins						ADDRESS 918 Argyle Ave.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 42922 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE																							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																		TITLE (SPECIFY) Assistant MEDICAL EXAMINER						DATE SIGNED 6/12/79											
ACTUAL SIGNATURE <i>Ann M. Dixon</i>						M.D. <u>Ann M. Dixon, M.D.</u>												ADDRESS 111 Penn St. Balto., MD.																	
EXAMINER'S NAME (TYPE OR PRINT)																																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 6/15/79						23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.						23d. LOCATION CITY OR TOWN Balto. City						COUNTY Va.						STATE					
24. FUNERAL DIRECTOR NAME Charles A. Rice												25a. DATE REC'D. BY REGISTRAR JUN 19 1979												25b. REGISTRAR'S SIGNATURE <i>Barney McBrady</i>											
ADDRESS 1300 Eutaw Place																																			

14324



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Post retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Items 18b.  
Film #G533 7-16-79 as

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 4 2 2 5

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
Mary		A.		Haskins	6 16 1979		M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Female		Negro		10-2-90		88 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Baltimore, Md.		U.S.A.				Balto. City Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Ashburton NSG. Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.				Balto.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET AND NUMBER			
First Middle Last		First Middle Last		3520 N. Hilton Rd.			
Walter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
(If yes give war or dates of service)		218-10-3946		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>GANGRENE Left leg -</u>							2 weeks
DUE TO, OR AS A CONSEQUENCE OF <u>Cardio-vascular</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>Hypertensive CV disease with</u>							years
DUE TO, OR AS A CONSEQUENCE OF <u>paralysis right</u>							years
(c) <u>ASCVD</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
		HOUR A.M. Month Day Year P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town County State	
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
22a. I certify that (I) (this hospital) attended the deceased from <u>4/19</u> , 19 <u>67</u> , to <u>6/16</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/16</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE						22c. DATE SIGNED	
						6/19/79	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS	
Wm C March MD						25 E Red St Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		6/22/79		Mt. Auburn Cem.		Baltimore, Md.	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm C March F/H 1101 E. North Ave.				JUN 20 1979			



44-10-348

*[Handwritten signature]*

RECEIVED  
JAN 10 1964  
U.S. DEPT. OF JUSTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

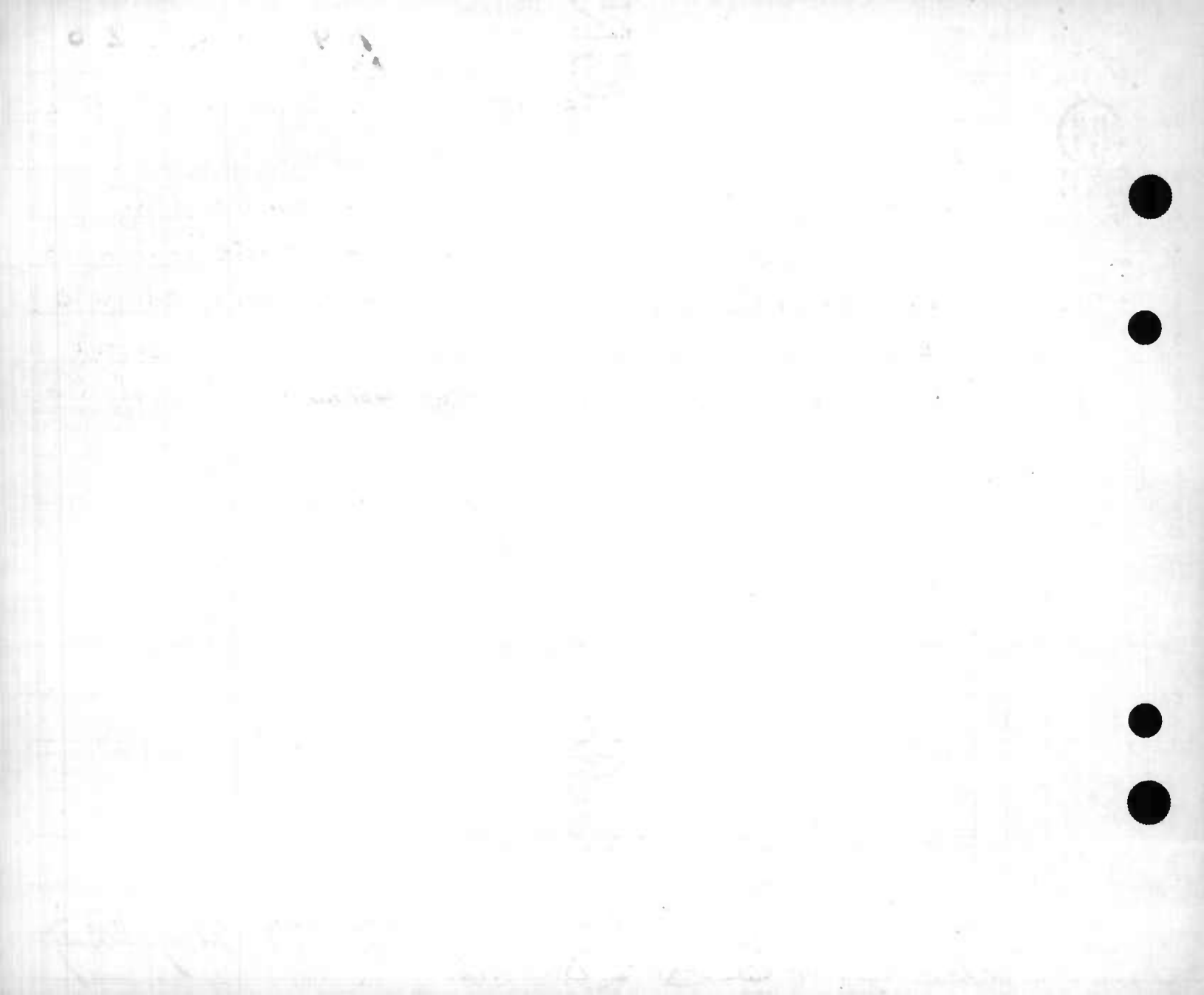
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 2 2 6  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
		Drema		MAY		HATmaker				June		6		1979				555 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS									
Female		Caucasian		2 4 43		36		MONTHS		DAYS		HOURS		MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
W. Va.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore City													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		BCRC, University Hosp		Housewife		own Home													
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
W Va		Rawleigh		odd		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt 71, Box 7, odd, W Va											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST									
A.		C.		Davis		Anne												Lester	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		NONE		232-84-7018		CHARLES HATMAKER (Husband)		Same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH																	
PART I. DEATH WAS CAUSED BY																			
IMMEDIATE CAUSE (a)		Cardiovascular Collapse																3 hours	
2050																			
DUE TO, OR AS A CONSEQUENCE OF		Sepsis																24 hours	
(b)																			
DUE TO, OR AS A CONSEQUENCE OF		Acute Myelocytic Leukemia																13 months	
(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
Intestinal Ileus																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)															
		HOUR A.M. MONTH DAY YEAR																	
		P.M. 19																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION															
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		DEGREE		22c. DATE SIGNED													
May 19 78, to June 19 79, that (I) (we) lost		Janice P. Dutcher		MD		6/6/79													
saw the deceased alive on June 6 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>															
above, (I) (we) (did) (did not) view the body after death.																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
JANICE P. DUTCHER		BCRC, University Hospital																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE							
Burial		6-10-79		Blue Ridge Mem Gardens		Prosperity						W. VA							
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
E. BARNES		FLEMING FUNERAL SERVICE Bensenville		JUN 11 1979															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		7 9 1 4 2 2 7 REG. NO							
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
LAURA		HAUPT						6-21-79 8P M	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Fem.		Cau.		1 7 89		90 YRS		8P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U.S.A.				BALTIMORE CITY		MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		UNION MEMORIAL HOSPITAL		Seamstress		Retired			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		-		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4701 Greenhill Ave. 21206	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Julius		Rebecca		Haupt		Elsasser			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS		5763	
No		215-09-9376		Mrs. E. Virginia Starrett		White Ave.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> 586- DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (1) <del>(the hospital)</del> attended the deceased from <u>6-21-79</u> to <u>6-21-79</u> , that (1) <del>(we)</del> lost saw the deceased alive on <u>6-21-79</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above; (2) <del>(we did)</del> <del>(did not)</del> view the body after death.									
22b. SIGNATURE <u>Roy Z. Braunstein</u>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-21-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roy Z. BRAUNSTEIN		22e. ADDRESS 201 E. UNIV. PKWY BALT, MD. 21218							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-23-79		23c. NAME OF CEMETERY OR CREMATORY Balto. Cem.		23d. LOCATION CITY OR TOWN COUNTY MD.		Balto. MD.	
24 FUNERAL DIRECTOR NAME John C. Miller Inc.				ADDRESS 6415 Belair Rd.		25a. DATE REC'D. BY REGISTRAR JUN 25 1979		25b. REGISTRAR'S SIGNATURE <u>Rodney McBrady</u>	

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<b>STATE OF MARYLAND</b> <b>DEPARTMENT OF HEALTH AND MENTAL HYGIENE</b> <b>CERTIFICATE OF DEATH</b>										7 9 1 4 2 2 8		
FOR STATE REGISTRAR										REG. NO.		
<b>I. DECEASED NAME</b> (TYPE OR PRINT)		FIRST <b>Adolph</b>		MIDDLE <b>Frederick</b>		LAST <b>Hauser</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>June 11, 1979</b>			2b. HOUR <b>1:15 P.M.</b>	
3. SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 26, 1893</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7c. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>323 Westowne Road</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Naval Lab, Wash, D.C.-retired</b>			12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>323 Westowne Road</b>			<b>21229</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick Hauser</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sadie</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>214-05-3022</b>		17. INFORMANT ADDRESS <b>Ethel G. Hauser, 323 Westowne Road</b>								
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>m myocardial infarction</u> <u>410 -</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. } DUE TO, OR AS A CONSEQUENCE OF (b) <u>A SCVD</u> } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>emphysema, cerebrovascular insufficiency, renal insufficiency</u>												
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>79</u> , to <u>June 11</u> , 19 <u>79</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>May 16</u> , 19 <u>79</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>do not</del> ) view the body after death.												
22b. SIGNATURE <i>J. Nelson McKay</i> DEGREE <i>M.D.</i>								22c. DATE SIGNED <b>6/12/79</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. J. Nelson McKay</b>				22e. ADDRESS <b>1132 N. Rolling Road 21228</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/14/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>Witzke Funeral Home of Catonsville, P.A. 21228</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1979</b>		25b. REGISTRAR'S SIGNATURE <i>R. J. ...</i>				

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 4 2 2 9	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary R. Hayden						2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/> MONTH DAY YEAR 6 25 19 79		2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR MAY 25, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 25 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore City				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) TYPIST		12b. KIND OF BUSINESS OR INDUSTRY OFFICE	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1120 RAMBLEWOOD RD. 21239			
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM ROBINSON						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? ? ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-40-4162		17. INFORMANT ADDRESS ELIZABETH RUARK 403 ALABAMA RD. 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. HEAD ONLY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		HEAD ONLY			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 6/25/79			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 6/29/1979		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE			
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME 6500 YORK RD.						25a. DATE RECEIVED BY REGISTRAR JUL 2 1979 REGISTRAR <u>John P. McCready</u>					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 1 4 2 3 0 REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST <u>PHILIP</u> MIDDLE LAST <u>HAZELTON</u>				2a. DATE OF DEATH MONTH <u>6</u> DAY <u>7</u> YEAR <u>79</u>				2b. HOUR <u>9.00</u> <u>A</u>			
3. SEX <u>male</u>		4 RACE <u>Black</u>		5. DATE OF BIRTH MONTH <u>10</u> DAY <u>29</u> YEAR <u>99</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>79</u>		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pa.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.					
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Lutheran Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <u>md.</u>		13b. COUNTY		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>11 W 20th Street</u>			
14. FATHER'S NAME FIRST <u>Joseph</u> MIDDLE LAST <u>Hazelton</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Anna</u> MIDDLE LAST <u>Hazelton</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <u>212122455</u>		17 INFORMANT <u>ROSE HAZELTON</u> ADDRESS <u>(Same)</u>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>2754</u> <u>CARDIORESPIRATORY ARREST * ASPIRATION</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPERTENSIVE CARDIOVASCULAR DS</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSIVE CHR. BRN SYND.</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR <u></u> A.M. MONTH <u></u> DAY <u>19</u> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-1-79</u> to <u>6-7-79</u> , that (I) (we) last saw the deceased alive on <u>6-7-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not view the body after death.)											
22b. SIGNATURE <u>Abdul Samad Khan</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>6-7-79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ABDUL SAMAD KHAN</u>				22e. ADDRESS <u>Lutheran Hospital MD. Baltimore</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>6/11/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Western Star Cem</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Catonville, Md.</u>			
24 FUNERAL DIRECTOR NAME <u>Charles A. Rice</u> ADDRESS <u>1300 Eutaw Pl.</u>						25a. DATE REC'D. BY REGISTRAR <u>JUN 12 1979</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Agnes HEALY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 14 1979</b>			2b. HOUR <b>5:20A M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 21 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS</b>	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		8b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>unknown</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. STREET ADDRESS <b>Gr. Penn. Nurs. Center 607 Pennsylvania Avenue 21217</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>unknown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>unknown</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>138-03-2467</b>		17. MEDICAL RECORDS ADDRESS <b>Maryland General Hospital 827 Linden Avenue</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia - Probable Aspiration</b> 438 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Old Right Cerebral Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 12</b> , 19 <b>79</b> , to <b>June 14</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>June 14</b> , 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.									
22b. SIGNATURE <b>Marc S. Kallins</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>6-14-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marc S. Kallins, M.D.</b>						22e. ADDRESS <b>c/o Maryland General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>6/20/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEARTS</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>DUNDALK BALTO MD.</b>		
24. FUNERAL DIRECTOR NAME <b>CONNELLY F.H.</b>						ADDRESS <b>300 MACE AVE</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>	
						25b. REGISTRAR'S SIGNATURE <b>History McCreedy</b>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9		1 4 2 3 2		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>IDA - HEATH</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6-2-1979</b>		2b. HOUR <b>7:35 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 25 16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1402 Argyle Avenue</b>			
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Howard West</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Amelia Payne</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>169-22-7435</b>		17. INFORMANT ADDRESS <b>Edna Gaines 3809 Wabash Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Diabetes Mellitus</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary Tuberculosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardio-Respiratory Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>-</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>-</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>-</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>6-1-1979</b> to <b>6-2-1979</b> , that (I) (we) last saw the deceased alive on <b>6-2-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>B. Narayana</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6-2-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/6/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Co., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barney McCreedy</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 1 4 2 3 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>I Gail Heffner</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>June 22, 1979</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct 19, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1300 Weldon Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Meat Cutter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail Store</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>Md</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Baltimore</b>		13e. STREET ADDRESS <b>1300 Weldon Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Heffner</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes Laird</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>232 22 2853</b>		17. INFORMANT ADDRESS <b>Margaret Heffner Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>Ca lung</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (d) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yr.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/19/79</b> to <b>6/22/79</b> , that (I) (we) lost saw the deceased alive on <b>6/19/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Robert J. Mahon</b>				DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Robert Mahon, Jr.</b>				22e. ADDRESS <b>204 E. Joppa Road</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview Mem. Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Eldersburg Carroll Md</b>	
24. FUNERAL DIRECTOR NAME <b>Burgee Funeral Home</b> ADDRESS <b>3631 Falls Road 21211</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 25 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert J. Mahon</b>	

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1919	1919	1919	1919	1919	1919
1919	1919	1919	1919	1919	1919
1919	1919	1919	1919	1919	1919
1919	1919	1919	1919	1919	1919
1919	1919	1919	1919	1919	1919
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1919	1919	1919	1919	1919	1919
1919	1919	1919	1919	1919	1919
1919	1919	1919	1919	1919	1919

*[Faint, illegible handwriting and markings]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7. 9		1 4 2 3 4		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Rev. Martin B. HEILAND					2a. DATE OF DEATH MONTH DAY YEAR June 18, 1979			2b. HOUR 10:30 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8-29-1885		6. AGE (IN YEARS LAST BIRTHDAY) 93		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) York Co., Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister		12b. KIND OF BUSINESS OR INDUSTRY Religion			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY BALTO.		13c. CITY OR TOWN Freeland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Moses Byron Heiland					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Wasser						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 187-30-0061		17. INFORMANT Sallie R. Heiland			ADDRESS Freeland R.D., Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YEARS.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 7</u> , 19 <u>78</u> , to <u>APRIL 18</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>APRIL 18</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <u>Fredric R. Weiner</u>				DEGREE MD.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-19-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fredric R. Weiner, MD				22e. ADDRESS Market Square, Shrewsbury, Pa. 17361							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-22-79		23c. NAME OF CEMETERY OR CREMATORY Heiland View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE York Twp., York Co., Penna.		25a. DATE REC'D BY REGISTRAR JUN 25 1979			
24. FUNERAL DIRECTOR NAME <u>C. J. Hartenstein, New Freedom, Pa.</u>				25b. REGISTRAR'S SIGNATURE <u>Anthony McCready</u>							

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11/10/1910





1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Anna</b>		FIRST <b>Anna</b>		MIDDLE <b>Helowicz</b>	LAST <b>Helowicz</b>	2a. DATE OF DEATH MONTH DAY YEAR <b>June 20, 1979</b>		2b. HOUR <b>9:40 a.m.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 15, 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>723 South Ann Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cannery</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>723 S. Ann Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Peter Bogdan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Mika</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-07-8977</b>		17. INFORMANT <b>Theresa H. Beksinski</b>		ADDRESS <b>2418 Pelham Ave. #21213</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LEFT CEREBROVASCULAR THROMBOSIS</b> <b>4340</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ESSENTIAL HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>NEUROGENIC BLADDER</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4-4-79</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>NEUROGENIC BLADDER</b>									
19a. DATE OF OPERATION <b>APRIL 4, 1979</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NEUROGENIC BLADDER</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 4, 1979</b> , to <b>JUNE 20, 1979</b> , that (I) (we) lost saw the deceased alive on <b>6-20</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Marion C. Kowalewski MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>6-21-79</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARION C. KOWALEWSKI</b>				22e. ADDRESS <b>8604 HARFORD RD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/23/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>George A. Weber &amp; Sons, Inc.</b>				ADDRESS <b>705 S. Ann St.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>	

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

08:41 PM



100-1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			7. 9 1 4 2 3 6				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR		
Walter C. Heltzel Jr.			6 12 79		12 <sup>00</sup> a.m.					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
Male		White		April 23, 1921		58		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.				Baltimore City MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		UNION MEMORIAL HOSPITAL				Production		Steel		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5511 Bel Air Rd. 21206	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Walter C. Heltzel			Anna K. Stevenson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Yes			WW II		220-07-5038		Miss Stephanie M. Heltzel		Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a): Crystole										
DUE TO, OR AS A CONSEQUENCE OF (b): Respiratory failure										
DUE TO, OR AS A CONSEQUENCE OF (c): Metastatic anaplastic cancer										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Chronic renal failure, hypercalcemia, hyperuricemia										
19a. DATE OF OPERATION										
4/3/79										
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										
Cardiac catheterization										
20a. AUTOPSY										
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
21b. TIME OF INJURY										
HOUR A.M. MONTH DAY YEAR										
P.M. 1 3 79										
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
Auto accident										
21d. INJURY OCCURRED										
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)										
21f. LOCATION										
STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 5/30 19 79 to 6/11 19 79 that (I) (we) last saw the deceased alive on 6/11 19 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE										
GREGORY FAITH										
22c. PHYSICIAN'S NAME (TYPE OR PRINT)										
Gregory Faith										
22d. ADDRESS										
UNION MEMORIAL Hospital										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		STATE	
Burial			June 15, 1979		Most Holy Redeemer		Baltimore		Maryland	
24. FUNERAL DIRECTOR										
NAME Leonard J. Ruck, Inc. ADDRESS Balto, Md.										
25a. DATE REC'D. BY REGISTRAR										
JUN 15 1979										
25b. REGISTRAR'S SIGNATURE										
Anthony McBrady										





78 14230

April 23, 1951

White

Male

Washington

State

1951

Washington

Washington

Washington

State

Washington

Washington

State

Washington

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - STATE REGISTRAR					REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) <b>ANNE LEE HENDERSON</b>					2a DATE OF DEATH MONTH DAY YEAR <b>JUNE 12, 1979</b>					2b HOUR <b>9:55p M</b>
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>3 01 1908</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>71</b>		7 IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>		8 IF UNDER 24 HRS. HOURS MIN. <b>MD.</b>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b>				
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MARYLAND GENERAL HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Resident Manager</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Apts. Esplanade</b>		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>					13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Henderson, Sr.</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lela Carey</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-07-4544</b>		17 INFORMANT ADDRESS <b>Thomas Henderson 9824 Magledt Rd.</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURED RIGHT INTERNAL CAROTID ARTERY ANEURYSM 3 Days</b> <b>430-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 9</b> , 19 <b>79</b> , to <b>June 12</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 12</b> , 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did not) view the body after death.										
22b. SIGNATURE <i>Gary Posner</i>					DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>6/12/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GARY POSNER, M.D.</b>					22e. ADDRESS <b>c/o MARYLAND GENERAL HOSPITAL</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/15/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Overlea Baltimore Md.</b>				
24 FUNERAL DIRECTOR NAME <b>Lsahn Funeral Home</b>					ADDRESS <b>7401 Belair Road</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1979</b>			

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51. 2003.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

1 4 2 3 8

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Florence E. Henneman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>06-18-79</b>		2b. HOUR <b>M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 18 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>
13a. STATE <b>MD</b>			13b. CITY OR TOWN <b>Baltimore</b>	13c. STREET ADDRESS <b>4007 Northern Parkway</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Marshall Shipley</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Ann Wagner</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-34-5212</b>		17. INFORMANT ADDRESS <b>Mrs. Elaine Fitzhugh</b> <b>3326 Courtleigh Drive, Baltimore, MD 21207</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1579</b> IMMEDIATE CAUSE (a) <b>CARCINOMA OF PANCREAS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CEREBRAL VASCULAR ACCIDENT</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 YR.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>DIABETES MELLITUS</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/26, 1979</b> to <b>6/18, 1979</b> , that (I) (we) last saw the deceased alive on <b>6/18, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Fredric Stewart Sirkis MD</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>6/18/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FREDRIC STEWART SIRKIS</b>			22e. ADDRESS <b>MERCY HOSP. 301 ST. PAUL ST.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/21/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City MD</b>
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, P.A.</b> ADDRESS <b>8728 Liberty Road, Randallstown, MD 21133</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 20 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Loring Byers</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

88-41-97

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535



RECEIVED  
JAN 10 1964



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A 15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 4 2 3 9

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST CHARLES			MIDDLE W.			LAST HENSON, JR.			2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/>			MONTH 6			DAY 5			YEAR 19 79			2b. HOUR M 5:33 a			
3. SEX male		4. RACE negro		5. DATE OF BIRTH MONTH DAY YEAR 1 13 43		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			MONTH 6			DAY 5			YEAR 19 79			24 HOUR a			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.															
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) doorway of 4002 Oakford Ave.								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE Md.				13b. COUNTY				13c. CITY OR TOWN Balto.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 2842 Gatehouse Rd.											
14. FATHER'S NAME FIRST MIDDLE LAST Charles Henson, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Foskey																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				(IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 217-38-1190				17. INFORMANT Helen Foskey												ADDRESS 2842 Gatehouse Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) Gunshot wounds of head & neck (unspecified weapon) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR XXX 6-5- 19 79				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject found shot.																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) doorway of				21f. LOCATION STREET 4002 Oakford Ave.				CITY OR TOWN Balto.				COUNTY				STATE Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																											
ACTUAL SIGNATURE Ann M. Dixon				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER												DATE SIGNED 6-5-79											
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St.																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/9/79				23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.				23d. LOCATION CITY OR TOWN Arbutus, Md.				COUNTY				STATE							
24. FUNERAL DIRECTOR NAME Wm C March F/H												ADDRESS 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR JUN 7 1979				25b. REGISTRAR'S SIGNATURE Petry/Nebrudy							

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- STATE REGISTRAR <b>Items 18c. Film G533</b> <b>7-23-79 as</b> <b>7 9 1 4 2 4 0</b> CERTIFICATE OF DEATH REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Linda Y. HENSON (Brooks)</b>					2a DATE OF DEATH MONTH DAY YEAR <b>June 27 1979</b>			2b HOUR <b>6:20P M</b>	
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 20 49</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>29</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>md</b> 13b COUNTY <b>-</b> 13c CITY OR TOWN <b>Baltimore</b>					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>1710 Edmonds on Ave</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>James E. Brooks</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Beulah E. Snowlen</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>214-56-1152</b>		17 INFORMANT ADDRESS <b>Charles H. Henson Jr. 1710 Edmonds on Ave Baltimore, Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Congestion And Edema</b> 674- DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Recent myocardial infarction</b> (c) <b>Probable post-partum Cardiomypathy</b> 6/26/79									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs</b> <b>8 hrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) <del>XXXXXX</del> attended the deceased from <b>June 26</b> , 19 <b>79</b> , to <b>June 27</b> , 19 <b>79</b> , that (I) <del>XXX</del> lost saw the deceased alive on <b>June 27</b> , 19 <b>79</b> , and that in (my) <del>XX</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>XX</del> (did) <del>XXXX</del> view the body after death									
22b SIGNATURE <b>Mark S. Kaplan</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <b>6/29/79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mark S. Kaplan, M.D.</b>					22e ADDRESS <b>c/o 16918 York Road, Monkton, MD. 21111</b>				
23a BURIAL, CREMATION, REMOVAL (CHECK ONE) <b>Burial</b>		23b DATE <b>7/3/79</b>		23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn AA Co Md</b>			
24 FUNERAL DIRECTOR NAME <b>Burnell B. Oden</b>					ADDRESS <b>4101 Edmonds on Ave</b>		25a DATE REC'D. BY REGISTRAR <b>JUN 29 1979</b>		25b REGISTRAR'S SIGNATURE <i>propy, H. Brady</i>

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 14241

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	6 / 24/79			6:15A
Lena				Herz				
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
FEMALE	WHITE	MONTH / DAY / YEAR		101		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
W. VIRGINIA		U.S.A.				Balto. City MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Balto. City		House in the Pines Belvedere		NONE		NONE		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS		
Md.				Balto.		Concord House 2500 W. Bely		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		
MOSES		HERZ		NO		220-44-35947		
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4029		19. ADDRESS		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
WILLIAM R. KAHN		Acute C.V.D. - Cardiac arrest		7903 LONG MEADOW RD.		6/24/79		
21. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		22. DUE TO, OR AS A CONSEQUENCE OF		23. DUE TO, OR AS A CONSEQUENCE OF		24. PROBABLE CAUSE		
		Cardiac + Coronary artery - previous Pulmonary embolism		Hypertension C.V.D. - art. sclerotic C.V.D. - long Hopen		6/19/79		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		HOUR A.M. MONTH DAY YEAR						
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4/12/79, 1979, to 6/24/79, 1979, that (I) (we) last saw the deceased alive on 6/23, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		22c. DATE SIGNED				
Bernard J. Cohen M.D.				6/24/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
BERNARD J. COHEN. MD		The Marylander apt 3501 St. Paul St						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
BURIAL		6/25/79		OHEB SHALOM		BALTIMORE COUNTY MARYLAND		
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE		
Sol Levenson Bros		6010 REISTERSTOWN RD. BALTO., MD 21215		JUN 27 1979		Dorothy McBreedy		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 351-1234.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 79 14242						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Sara Elizabeth Hess</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>June 2, 1979</b>			2b. HOUR <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 15 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>77</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1519 Cole Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Maryland none Balto. City</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1519 Cole Street</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harrison Lucas</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ellen Wells</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>n/a</b>		17. INFORMANT (daughter) ADDRESS <b>Middle River, Md. Mrs. Avaneil M. Bradford</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous Cell Carcinoma - Cervix</b> <b>1809</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Congestive Heart Failure</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>4/4</b> , 19 <b>79</b> , to <b>6/2</b> , 19 <b>72</b> , that (I) (we) lost saw the deceased alive on <b>5-5</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Joseph H Miller, MD</b>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/3/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 6, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk. ElkrIDGE, Howard, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home, Glen Burnie, Md.</b>				ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>JUN 5 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Anthony K. Brady</i>	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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1. FOR STATE REGISTRAR		20. DATE OF DEATH		21. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		20. MONTH		21. P. M.	
WILLIAM JACOB HESS		JUNE 23, 1979			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
MALE	WHITE	DEC. 29, 1909	69 YRS.	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
DARMSTADT, GERMANY	U.S.A.		BALTIMORE CITY, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE, MD.	3821 FOSTER AVE. # 21224.		RETIRED		MEAT CO.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.		-----	BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3821 FOSTER AVE. #21224.
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
HERBERT HESS		CAROLYN ZINN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
YES		W.W. II	2020 E. MONUMENT ST. BALTO., 21205, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic C.V. Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
					?
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					?
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 7</u> , 19 <u>77</u> , to <u>June 23, 1979</u> , that (I) (we) lost saw the deceased alive on <u>June 13</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Jason H. Gaskel MD.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<u>June 26, 1979</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
JASON H. GASKEL		637 S. CONKLING ST. BALTO., 21224, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL		6-27-79	SACRED HEART CEM.		7401 GERMAN HILL RD., DUNDALK, MD.
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>Charles J. Gailer &amp; Son, Inc.</u>		JUN 28 1979		<u>Anthony McCready</u>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 14244			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 6 18 79			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marthe J. Hessian				2b. HOUR 10 a.m.			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11 18 1900		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH city MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Md		13b. COUNTY A.A.		13c. CITY OR TOWN Baltimore		13e. STREET ADDRESS Hammonds Lane Nursing Home	
14. FATHER'S NAME FIRST MIDDLE LAST JACK CROWE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218 097 2053		17. INFORMANT ADDRESS HARRY HESSIAN 1524 MARCO DR.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest (b) Sepsis. Acute postero-septal and lateral myocardial infarct (c) RLL pneumonia DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) No sepsis. Sx							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6-15 19 79 to 6-18 19 79, that (I) (we) last saw the deceased alive on 6-18 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. Chaokh M.D.				22c. DATE SIGNED 6/18/79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. CHAO	
22e. ADDRESS 3001 S. Hanover St. SBGH.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/20/79		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE	
24. FUNERAL DIRECTOR NAME B. DABROWSKI & SON				25a. DATE RETURNED BY REGISTRAR 6/19/79			
ADDRESS 2818 E. BALTIMORE							

11244



*[Faint, illegible handwritten text covering the majority of the page, likely bleed-through from the reverse side.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ferdinand Heister</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6/30/79</i>		2b. HOUR <i>11:40 M</i>					
3. SEX <i>Male</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Aug. 21, 1915</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>62</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City MD.</i>				
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore Sinai Hosp</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Health Asst.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i>			13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Reisterstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>5 Caraway Rd, Reisterstown, Md. 21136</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Heister</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lucile Nichols</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>212-38-0209</i>		17. INFORMANT <i>Clifford Frey</i>			ADDRESS <i>5 Caraway Rd, Reisterstown, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Resp. failure.</i> <i>5570</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <i>overwhelming sepsis.</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Asterial embolism; bedsores; pneumonia; 2 days -</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <i>5/15/79</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Mesenteric art. embolism</i>			20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1979			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>5/17/79</i> , 1979, to <i>6/30/79</i> , 1979, that (I) (we) last saw the deceased alive on <i>6/20</i> , 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Dr. Zeitun</i>			DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>6/30</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Zeitun</i>			22e. ADDRESS <i>Sinai Hosp., Baltimore</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>July 3, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Mem. G.A.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Finksburg Carroll Md.</i>			
24. FUNERAL DIRECTOR NAME <i>H. J. C. Smith</i>			ADDRESS <i>Reisterstown Rd</i>			25a. DATE REC'D. BY REGISTRAR <i>JUL 5 1979</i>		25b. REGISTRAR'S SIGNATURE <i>H. J. C. Smith</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be examined and signed by the funeral director, page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 2 4 6

1. DECEASED NAME (TYPE OR PRINT) <b>Donald F. Hickman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 25, 1979</b>		2b. HOUR <b>7:55p</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8-22-16</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.J.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Balto</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sec.</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>	13b. COUNTY <b>AA</b>	13c. CITY OR TOWN <b>Beverly Hills</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>301 Community Rd</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Donald E. Hickman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Reuby Daugherty</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>265-10-7800</b>	17. INFORMANT ADDRESS <b>Wm. W. Cross - Phone</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASYSTOLE</b> <b>4241</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RESPIRATORY ARREST</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1H 10min</b> <b>1H 15min</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>6/20/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>AORTIC STENOSIS / CORONARY ARTERY DISEASE</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 18</b> , 19 <b>79</b> , to <b>JUNE 25</b> , 19 <b>79</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>JUNE 25</b> , 19 <b>79</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)					
22b. SIGNATURE <b>Christopher S. McCullough</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/25/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHRISTOPHER S. MCCULLOUGH</b>		22e. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/28/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sumneridge Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crisfield Somerset, Md</b>
24. FUNERAL DIRECTOR NAME <b>Pat. J. Baranov</b>		ADDRESS <b>Beverly Hills</b>		25. DATE REC'D. BY REGISTRAR <b>JUN 29 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>Henry McCready</b>	

MEDICAL CERTIFICATION





01044



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 14247

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
FIRST MIDDLE LAST <i>Frederick T. Hicks</i>		6/19/79		2:50 P.M.			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
M	B	MONTH DAY YEAR 4 19 00	79 YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
MD.	USA		Baltimore City MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Balto.	Provident Hosp.				P.O. City		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1917 N. Eutaw St.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Thomas Hicks		Sarah Osbourne					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		216-44-9325		Celestine S. Hicks 1917 N. Eutaw Pl.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio respiratory arrest</i> 4029 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive heart failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertension</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes 8 yrs. 25 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
<i>Diabetes mellitus</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from saw the deceased prior or above, (I) (we) (did) (did not) view the body after death.		6/19/79 19 77		6/19/79 19 77			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<i>L. Young</i>						6/19/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		6/23/79		Mt. Auburn Cem.		Baltimore, Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm C. March F/H		1101 E. North Ave.		JUN 22 1979		<i>Richard McCreedy</i>	

BP

48419

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 2 4 8

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas Haines Hines			2a. DATE OF DEATH MONTH DAY YEAR 6-5-79		2b. HOUR 1210 AM	
3. SEX M		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 8 19 31		
6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? US		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ✓		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		
12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 4808 Lorelly Ave						
14. FATHER'S NAME FIRST MIDDLE LAST John Hines			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lilly Hanson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 226 34 3520		17. INFORMANT ADDRESS Lillette Whiting 4808 Lorelly Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b): Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c): APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 11 yrs						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Hypertension						
19a. DATE OF OPERATION 2/1/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary Artery Obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 26 Feb 79, 19 to 28 May 1979, that (I) (we) last saw the deceased alive on 28 May 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.						
22b. SIGNATURE David C Green MD		DEGREE MD		22c. DATE SIGNED 5 Jun 79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David C Green MD		22e. ADDRESS University Hospital 2250 Greene St Baltimore				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/9/79		23c. NAME OF CEMETERY OR CREMATORY Balto. Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.						
24. FUNERAL DIRECTOR NAME Wm C March F/H		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 7 1979		
25b. REGISTRAR'S SIGNATURE Ruthy Mabury						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0 2 5 4 1 2 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna M. Hinrichs					2a. DATE OF DEATH MONTH DAY YEAR 6 8 79					2b. HOUR 950 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 21, 1882		6. AGE (IN YEARS LAST BIRTHDAY) 96 years YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN COLUMBIA, GIVE STREET ADDRESS) Keswick Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleslady			12b. KIND OF BUSINESS OR INDUSTRY O'Neill & Co.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2500 Arbuton Avenue 21230		
14. FATHER'S NAME FIRST MIDDLE LAST John Hinrichs					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Theile					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 212-03-0287	
17. INFORMANT Mr. Raymond W. Hinrichs, 705 Milford Mill Rd					17. ADDRESS 21208					17. ADDRESS 21208		17. ADDRESS 21208	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular Failure</i> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Cardiovascular Dis</i> 10 yrs DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) <i>attended the deceased from</i> <i>6/8/79</i> <i>19 79</i> , to <i>6/18/79</i> <i>19 79</i> , that (I) <i>last</i> saw the deceased alive on <i>6/8/79</i> <i>19 79</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (If <i>seen</i> (add) <i>view the body after death</i> )													
22b. SIGNATURE <i>A. Allan Spier</i>						DEGREE <i>M.D.</i>			22c. DATE SIGNED <i>6/8/79</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A. ALLAN SPIER</i>						22e. ADDRESS <i>700 W. 40th St. BALTIMORE, MD 21211</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/11/79			23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland				
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.						24. ADDRESS Balto., Md. 21229			24. DATE REC'D. BY REGISTRAR JUN 11 1979				

14344

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



Memorandum

To: Mr. [illegible]  
From: Mr. [illegible]  
Subject: [illegible]

[illegible text]

[illegible text]

[illegible text]

[illegible text]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					7 9 1 4 2 5 0 REG. NO.					
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR					
1. DECEASED NAME (TYPE IN FULL) FIRST MIDDLE LAST AWAR C. Hogan					June 27 1979 9:15 A.M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 - 16 - 09		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto, Ind.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto City MD.				
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Montgomery Ward		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN Ind. Baltco					13e. STREET ADDRESS 2815 Oswege Ave. 21215					
14. FATHER'S NAME FIRST MIDDLE LAST John Hogan					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Mc Namara					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. -					
16c. INFORMANT John Hogan					ADDRESS 2815 Oswege Ave. 21215					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure + Comp 0709 DUE TO, OR AS A CONSEQUENCE OF: (b) Acute Viral Hepatitis - Fulminant DUE TO, OR AS A CONSEQUENCE OF: (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 1 month										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Arteriosclerotic coronary vascular disease, Renal insufficiency										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from June 8, 19 79, to June 27, 19 79, that (I) (we) lost saw the deceased alive on June 27, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John T. Salkeld					DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John T. Salkeld					22e. ADDRESS Mercy Hospital Balto Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-30-79		23c. NAME OF CEMETERY OR CREMATORY New Catholic Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Ind.			
24. FUNERAL DIRECTOR NAME John Cowan & Son, Inc. 901 Hallmark Bldg.					ADDRESS Baltimore, Md. 21223		25a. DATE REC'D. BY REGISTRAR JUL 6 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

BP





*[Faint handwritten text]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1 - STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 4 2 5 1			
1. DECEASED NAME				2a. DATE OF DEATH				REG. NO.			
FIRST MIDDLE LAST				MONTH DAY YEAR				2b. HOUR			
ELAINE R. HOLTZNER				6 24 79				6 35 M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
F		W		MONTH DAY YEAR		81 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
DELAWARE		USA				BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		ST AGNES HOSPITAL				HOMEMAKER					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND				BALTIMORE		CATONSVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		35 BLOOMSBURY AVENUE, 21228	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				ADDRESS			
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
BENJAMIN MOORE				ALMA HARRINGTON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT					
NO				213-74-4655		GEORGE E. HOLTZNER, 712 KENT AVENUE, 21228					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) obstructive jaundice											
2390 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) pancreatic tumor											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
6/8/79			Met. Obstructive jaundice			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June 2, 1979, to June 24, 1979, that (I) (we) lost saw the deceased alive on June 24, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED		
McDermott			M.D.						6/24/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
WAYNE McDERMOTT, M.D.						S.T. Agnes Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
BURIAL			06-27-79		MEADOWRIDGE MEM. PK.			ELKRIDGE			
								COUNTY STATE			
								HOWARD MARYLAND			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS						21229					
HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.						JUN 25 1979		Hickory McCreedy			

YTD 2004

JOURNAL OF DOCUMENTATION

300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79 14252	
1. FOR STATE REGISTRAR		REG. NO.			
1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR
Ada		Urilla	Hood		June 8, 1979
3 SEX		4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	7b HOUR
Female		White	June 3, 1883 <sup>R</sup>	96	5:05 <sup>P</sup> M
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.		Baltimore City MD	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore		Maryland General Hospital			
13a STATE		13b COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e STREET ADDRESS
Maryland		BALTO	Parkville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	7905 Oakdale Avenue
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
Jacob W. Bemisdarfer			America Snyder		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17 INFORMANT ADDRESS		
no		219-54-1119	Mrs. Carrye B. Harris, Parkville, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Atherosclerotic and hypertensive cardiovascular disease</u> <u>4149</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Left ventricular hypertrophy</u> (c) <u>Atherosclerotic narrowing of coronary arteries with cardiac ischemia</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
May 30, 1979 June 6, 1979		Cataracts, right eye Cataracts, Left eye		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <del>the deceased</del> attended the deceased from <u>May 22</u> , 19 <u>79</u> , to <u>June 8</u> , 19 <u>79</u> , that (I) <del>the deceased</del> saw the deceased alive on <u>June 8</u> , 19 <u>79</u> , and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) <del>not</del> view the body after death.		22b. SIGNATURE <u>Henry B. Wilson</u>		22c. DATE SIGNED <u>June 10, 1979</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Henry B. Wilson M.D.		6 East Eager St., Baltimore, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		June 12, 1979	Rose Hill Cemetery	Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		
Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740			JUN 14 1979 <u>Anthony McCready</u>		

MEDICAL CERTIFICATION



Baltimore 1937

Baltimore General Hospital

Atrophic gastritis of chronic nature with

loss of gastric mucosa

atrophy of gastric mucosa and hyperplasia of

gastric mucosa

gastric mucosa, right side  
gastric mucosa, left side

May 30, 1937  
June 2, 1937

X

Chiefly gastric, Baltimore, MD.

Chiefly gastric, Baltimore, MD.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

14253

REG. NO.

1. FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>BURL</b>		FIRST <b>HOOD</b>		MIDDLE <b>JR</b>		LAST		2a. DATE OF DEATH MONTH <b>6</b> DAY <b>16</b> YEAR <b>79</b>		2b. HOUR <b>5:45 A M</b>	
3 SEX <b>MALE</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH <b>3</b> YEAR <b>22</b> DAY <b>02</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>77</b>		IF UNDER 1 YEAR MONTHS <b>77</b> DAYS <b>YRS</b>		IF UNDER 24 HRS HOURS <b>MIN.</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ga.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.					
10 CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident</b>						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>703 Alleghany Place</b>			
14 FATHER'S NAME FIRST <b>Burl</b> MIDDLE <b>Hood, Sr.</b> LAST						15 MOTHER'S MAIDEN NAME FIRST <b>Rosemary</b> MIDDLE <b>ROSEMARY</b> LAST					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>244-12-6436</b>		17 INFORMANT <b>James Hood</b>		ADDRESS <b>1646 Bruce Ct.</b>					

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Cardiac Arrhythmia

4140

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 hour

years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (10)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/10</u> , 19 <u>79</u> , to <u>6/16</u> , 19 <u>79</u> , that (I) <del>(we)</del> lost saw the deceased alive on <u>6/15</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Roland T. Smoot M.D.</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/22/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROLAND T. SMOOT, M.D.</b>		22e. ADDRESS <b>2300 GARRISON BLVD. 21216</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/21/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>		23d. LOCATION CITY OR TOWN <b>Balto. Co., Md.</b> COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>		ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>		25b. REGISTRAR'S SIGNATURE <u>L. H. McCreedy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

02241-11

(14)



## EXAMINER'S OFFICE

TO HOSPITAL'S ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 4 2 5 4	
FOR 1 - STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>ELSIE B. HOOD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 03 1979</b>		2b. HOUR <b>09:22 AM</b>
3 SEX <b>Female</b>	4 RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 4 25</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10 CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2216 Prentiss Pl.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Noah Cropper</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Clark</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS <b>Howard Hood 3029 E. Federal St.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CP Aneurysm</b> <b>410 -</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Possible stroke</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Also 65 bleed.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>unknown</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6/3</b> , 19 <b>79</b> , to <b>-6/3/79</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>never</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Heuser</b>		DEGREE		22c. DATE SIGNED <b>9/3/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Heuser</b>		22e. ADDRESS <b>JHH</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/9/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>		24 FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H 1101 E. North Ave.</b>			
25a. DATE REC'D. BY REGISTRAR <b>JUN 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony M. Hardy</b>			

1951-1952





1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 4 2 5 5

1. DECEASED NAME (TYPE OR PRINT) <b>EDITH L. HOOKS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 11 79</b>			2b. HOUR <b>3:55A</b> M				
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 25 12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MARYLAND</b>			13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2007 HARMAN AVENUE, 21230</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CARL E. RIDENHOUR</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FRONNIE EURY</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>238-03-4469</b>		17. INFORMANT ADDRESS <b>PHILLIP E. HOOKS, FINKSBURG, MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DOA 5/9/79</b> <b>DOD 6/11/79</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Long standing hypertension &amp; COPD</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <b>May 19</b> , 19 <b>79</b> , to <b>June 11</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>June 11</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22a. SIGNATURE <b>D. Balana</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. Balana Kalaria</b>			22e. ADDRESS <b>900 S. CATON AVE BALTO MD 21229</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL/BURIAL</b>			23b. DATE <b>06-14-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAKWOOD CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CONCORD N.C.</b>			
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>			ADDRESS <b>4107 WILKENS AVE.</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 13 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Frederick Melroedy</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by balance.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



BALTIMORE CITY

ST. JOSEPH HOSPITAL

BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 2 5 6

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Bera M Hooper			2a. DATE OF DEATH MONTH DAY YEAR 6 11 79			2b. HOUR 9:50 AM					
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 7 26		6 AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician			12b. KIND OF BUSINESS OR INDUSTRY US		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALTO				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1016 Alexander Ave			
14 FATHER'S NAME FIRST MIDDLE LAST ERNEST Mills				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sallie Mae Prillman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 232-40-5301		17. INFORMANT ADDRESS Otis Hooper - 1016 Alexander Ave.					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) anoxic brain death 4939 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) respiratory failure DUE TO, OR AS A CONSEQUENCE OF (c) asthma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days 9 days 6 mos	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/3, 19 79, to 6/11, 19 79, that (I) (we) lost saw the deceased alive on 6/11, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Calvin Plitt				DEGREE MD		22c. DATE SIGNED 6/11/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Calvin Plitt				22e. ADDRESS University Hospital			

23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 6/14/79		23c. NAME OF CEMETERY OR CREMATORY Arboretum		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Linnell B. Oden - BALTO				25a. DATE REC'D. BY REGISTRAR JUN 12 1979		25b. REGISTRAR'S SIGNATURE R. H. H. H.	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 7/77  
(VRA 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 2 5 7

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>George J HORVATH sr</b>			2a. DATE OF DEATH MONTH <b>6</b> DAY <b>17</b> YEAR <b>79</b>			2b. HOUR <b>8 30</b> <b>PM</b>		
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>March</b> DAY <b>30</b> YEAR <b>1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospitals</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Auto Assembly</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>GMC.</b>								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) No. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Rosedale</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>5710 Kenwood Ave.</b>		
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>BUNAC</b> LAST <b>BUNAC</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE <b>Bunk</b> LAST <b>mant</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217030286</b>		17. INFORMANT ADDRESS <b>Dorothy M. Horvath 5710 Kenwood Ave</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>5789</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aspiration Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>GI Bleed</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>6/17</b> 19 <b>79</b> to <b>6/17</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/17</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>David Mishkin MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/17/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David Mishkin MD</b>				22e. ADDRESS <b>Balto. City Hosps</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-20-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenland Park Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>		
24. FUNERAL DIRECTOR NAME <b>City &amp; Co</b> ADDRESS <b>1211 Chesaco Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 18 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. ...</b>		





1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR		Reginald J. Hovermale				7 9 1 4 2 5 8 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Reginald J. Hovermale					2a. DATE OF DEATH MONTH DAY YEAR 6-10-79			2b. HOUR 3:30 A.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 29, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ruthenry Hospital of Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic Davidson		12b. KIND OF BUSINESS OR INDUSTRY Transfer		
13a. STATE Md.					13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3406 Park Heights Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Reginald Hovermale					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Bell Mallott					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT ADDRESS Mrs. Jennie E. Spring same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 496- Severe Chronic obstructive Lung Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 06-07, 1979, to 06-10, 1979, that (I) (we) last saw the deceased alive on 06-10, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Chaz Rehervarian					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/> DIRECTOR OF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6/10/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MOGHS GERREMARIAM					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 14, 1979		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland					25a. DATE REC'D. BY REGISTRAR JUN 12 1979			25b. REGISTRAR'S SIGNATURE Lillian M. Brady		

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3000 West Baltimore Ave.

Baltimore

Mr.

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James

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official

210-2-637 Mrs. James J. Smith

and

June 10, 1919

Dear

Enclosed is one copy of the report of the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14259

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		6-3-79		7 10 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Black		MONTH DAY YEAR		44 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
N.C.		USA				Baltimore city MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Balto.		Lutheran Hospital				Bethlehem steel	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD				Baltimore city		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		p20 N Braddish.			
Unkn		Unkn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Unknown		218286126		Gloria E. Howard		920 Braddish Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Ca. of larynx							
DUE TO, OR AS A CONSEQUENCE OF (b) Dehydration							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial insufficiency							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
MOGES GERBRE MARIAM				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		6-3-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Moges Gerbre Mariam							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		6/9/79		King Memorial Pk.		Baltimore Co., Md.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS				JUN 7 1979		[Signature]	
Wm C. March F. H.				1101 E. North Ave.			

1 4 3 2 9

Wm C. March R. H. 1101 E. North Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 4 2 6 0									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Henry		M.				Howell		6 26 79		M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		Black		11 30 1913		65 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		USA				Baltimore, City MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Balto.		Union Memorial Hospital						Chipper		R. R.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md				Balto				2142 Hollins Street			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
				Carrie Teal							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		244 03 5035		Ruby Howell		2142 Hollins Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4029 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHF, Hypertensive</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Coronary atherosclerosis (CABG)</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
				1978 May 24 1979							
22a. I certify that (I) (this hospital) attended the deceased from <u>May 24 1979</u> to <u>May 24 1979</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>E. S. Romero</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6-27-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>E. S. ROMERO</u>		22e. ADDRESS <u>1701 W. Pratt Street</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>6-30-79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Westview Mem Pk.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Maryland</u>					
24. FUNERAL DIRECTOR NAME <u>Isaiah L. Brown &amp; Son PA</u>				ADDRESS <u>1913 W. Balto. St.</u>				25a. DATE REC'D. BY REGISTRAR <u>JUN 28 1979</u>			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7-9		14261	
1. FOR STATE REGISTRAR				REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>Roger</b>				FIRST MIDDLE LAST <b>HOWELL</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 28, 1979</b>				2b. HOUR <b>3:33 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 18, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>84</b>		IF UNDER 24 HRS HOURS MIN. <b>3:33</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.							
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>112 St. Dunstons Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dean</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Law School</b>					
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>112 St. Dunstons Road</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Henry Howell</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anne Tucker</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WW 1</b>		17. INFORMANT ADDRESS <b>Roger Howell, Jr. Balto., Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the Lung</b> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>2. Emphysema</b> (c) <b>2. Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 weeks</b> <b>15 years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the hospital) attended the deceased from <b>1950</b> , 19____, to <b>Death</b> , 19____, that (I) (we) lost saw the deceased alive on <b>June 25, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE <b>Dr. Crawford N. Kirkpatrick, Jr.</b> DEGREE										22c. DATE SIGNED <b>6-29-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Crawford N. Kirkpatrick, Jr.</b>				22e. ADDRESS <b>6 E. Eager Street Balto., Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/2/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville, Md.</b>							
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barney McCreedy</b>					
24b. ADDRESS <b>4905 York Road Balto., Md. 21212</b>													

10541 71

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

14262

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Bertha Elizabeth Hoyer</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 11, 1979</b>			2b. HOUR <b>2:40A M</b>				
3 SEX <b>female</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>May 30, 1886</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md</b>			13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2211 W. Rogers Avenue</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Oliver Graham</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna B. Seward</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>216 07 7452D</b>		17 INFORMANT ADDRESS <b>The Wesley Home 2211 W. Rogers Avenue</b>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Stroke</b> 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 2</b> , 19 <b>79</b> , to <b>June 11</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>June 8</b> , 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.										
22b. SIGNATURE <b>Charles Graham M.D.</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/11/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles Graham M.D.</b>					22e. ADDRESS <b>c/o Maryland General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/14/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Balto. Md</b>			
24 FUNERAL DIRECTOR <b>Burgee Funeral Home</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

2

9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 4 2 6 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD J. HUCKE, SR.</b>				2a. DATE OF DEATH MONTH <b>6</b> DAY <b>16</b> YEAR <b>79</b>		2b. HOUR <b>5:55</b> A.M.	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>August</b> DAY <b>17</b> YEAR <b>1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired-Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Food Store</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>6115 Everall Ave. 21206</b>	
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>Hucke</b> LAST <b>Hucke</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Christine</b> MIDDLE <b>Nagel</b> LAST <b>Nagel</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-05-0931</b>		17. INFORMANT ADDRESS <b>Mrs. Mararetta Hucke, same as #13c</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPOTENSION</b> <b>4249</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RIGHT HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>VALVULAR HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER <b>N/A</b>		21b. TIME OF INJURY HOUR <b>N/A</b> A.M. MONTH <b>N/A</b> DAY <b>N/A</b> YEAR <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <b>N/A</b>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>		21f. LOCATION STREET <b>N/A</b> CITY OR TOWN <b>N/A</b> COUNTY <b>N/A</b> STATE <b>N/A</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>1:50 AM 6/16/79</b> to <b>4:55 AM 6/16/79</b> , that (I) (we) lost saw the deceased alive on <b>JUNE 16 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE <b>Randy L. Reese, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6/16/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RANDY L. REESE, M.D.</b>				22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/19/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>County</b> STATE <b>Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>5305 Harford Rd. Balto.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 18 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 5 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

60541-60542



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7	9	1	4	2	6	4
FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>Winefred M. Hudson</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>June 14, 1979</b>				2b. HOUR <b>8 A.M.</b>		
3. SEX <b>Female</b>			4. RACE <b>Black</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>3 30 18</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS HOURS MIN. <b>0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>Balto.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.							
10. CITY OR TOWN OF DEATH <b>Balto.</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>John L. Dexter Medical Ctr.</b>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>			13c. CITY OR TOWN <b>Balto.</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1901 E. 31st Street</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Donald Boyce</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Wilhelmina Griffin</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-30-6435</b>			17. INFORMANT <b>Jay D. Hudson</b>			ADDRESS <b>1901 E. 31st St.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningioma</b> <b>2252</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DU TO OR AS A CONSEQUENCE OF (b) <b>Electrolyte imbalance</b> DU TO OR AS A CONSEQUENCE OF (c) <b>Decubitus ulcers</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <b>July 26, 1978</b> to <b>June 14, 1979</b> , that (I) (we) lost saw the deceased alive on <b>June 14, 1979</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <b>Julian W. Reed</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JULIAN W. REED</b>						22e. ADDRESS <b>611 S. CHAS. ST. BALTO. MD 21220</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/18/79</b>			23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>							
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>						ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 18 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>						



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WATERLOO



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14265	
1- FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Robert Leslie Hunt</b>										2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 19 <b>6 6 79</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 6, 1958</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>21 YRS</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 19 <b>6 6 79</b>	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE, MD.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>124 N. Clinton Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UNEMPLOYED</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>				13b. COUNTY <b>-----</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>124 N. CLINTON ST. # 21224.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLARD F. HUNT</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LUCILLE D. COURTNEY</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>214-78-1212</b>		17. INFORMANT ADDRESS <b>LUCILLE D. HUNT : 124 N. CLINTON ST. BALTO., 21224, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Muscular dystrophy</b> 3591 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>6/7/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn Street, Balto., MD 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>6-9-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>TRINITY CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>5500 O'DONNELL ST., BALTO., MD.</b>			
24. FUNERAL DIRECTOR NAME <i>Charles S. Gales &amp; Son, Inc.</i>				ADDRESS <b>901 S. CONKLING ST. BALTO., 21224, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Lucy M. Brady</i>			

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Annie Mae Hunter			2a. DATE OF DEATH MONTH DAY YEAR 6 15 79			2b. HOUR M				
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 21 10		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Midtown Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1321 Eutaw Place	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Pride						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS James Duckett 633 N. Augusta Ave.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> <u>2252</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RECURRENT MENINGIOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <u>SEIZURE DISORDER</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>6-15</u> , 19 <u>77</u> to <u>6-15</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-6</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>JORGE E. GARCIA</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>6-18-79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JORGE E. GARCIA</u>				22e. ADDRESS <u>KIRK AND 22ND STS</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/20/79		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.			23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.			
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.			25a. DATE REC'D. BY REGISTRAR JUN 20 1979		25b. REGISTRAR'S SIGNATURE <u>R. J. Kennedy</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 2 6 7

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Luther</i>		FIRST <i>Hyatt</i>		LAST <i>Hyatt</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>6 16 79</i>		2b. HOUR <i>11:05 AM</i>	
3. SEX <i>M</i>		4. RACE <i>C</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>08 05 07</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>71</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO CITY</i> MD.			
10. CITY OR TOWN OF DEATH <i>BALT CITY</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>UMD Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>River Operator</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Amusement Park</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i>		13b. COUNTY <i>BALTO</i>		13c. CITY OR TOWN <i>BALT</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>9 S. Carey Street-21223</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Unknown</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Unknown</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>246-188-732A</i>		17. INFORMANT ADDRESS <i>Virginia Spruce - 9 S. Carey St. 21223</i>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>7999</i> IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>pneumonia</i>			
DUE TO, OR AS A CONSEQUENCE OF (c) <i>cerebral contusion</i>			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION <i>5/28/79</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>prolonged intubate</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>5/21/79</i> 19 <i>79</i> , to <i>6/16</i> 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>6/16</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Mark Carol</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>6/16</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARK CAROL</i>		22e. ADDRESS <i>UMD Hospital</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>6-19-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Hill Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>O.G. Co. Md.</i>	
24. FUNERAL DIRECTOR NAME <i>John E. Brown</i>		ADDRESS <i>Inc. 901 Hollins St.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 20 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Richard H. Brady</i>	

10241 88



BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 4 2 6 8

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Earl Albert Hymiller</b>		2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR <b>6 24 19 79</b>		2b. HOUR <b>M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 17, 1962</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>16 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN <b>6 24 19 79</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9a. CITY OR TOWN OF DEATH <b>Baltimore City</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>		
10. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cambridge Rubber Co.</b>		12b. KIND OF BUSINESS OR INDUSTRY
11a. STATE <b>Maryland</b>		11b. COUNTY <b>Carroll</b>	11c. CITY OR TOWN <b>Westminster</b>	11d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13a. STREET ADDRESS <b>35 Carroll View Ave.</b>		13b. STREET ADDRESS <b>35 Carroll View Ave.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Norman E. Hymiller Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hazel Mae Henry</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216 88 3672</b>		17. INFORMANT ADDRESS <b>Box 58 Tremanion Rd. Taneytown, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cranio cerebral trauma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR XX MONTH DAY YEAR <b>6:37 A.M. 6 15 19 79</b>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>occupant in motorcycle/auto collision</b>		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. 140 &amp; Royer Rd. Westminster, Carroll, MD</b>		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Thomas D. Smith, M.D.</b>		TITLE (SPECIFY) <b>Deputy Chief</b>		DATE SIGNED <b>6/25/79</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>		ADDRESS <b>111 Penn St. Balto., MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/27/1979</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Branch Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westminster Carroll Md.</b>		23e. DATE REC'D BY REGISTRAR <b>JUL 3 1979</b>		
24. FUNERAL DIRECTOR NAME <b>Thomas D. Fletcher &amp; Son Funeral Home</b>		25. ADDRESS <b>254 E. Main St. Westminster Md.</b>		

Albert

Dec. 17, 1961

U.S.A.

Executive Director

35 Carroll Way

Westchester

Yonkers, N.Y.

Mr. J. Edgar Hoover

FBI

Washington

Dear Sir:

Enclosed for you are two copies of a letterhead memorandum dated and captioned as above.

Very truly yours,

John Edgar Hoover  
Director

100-100000-100000

Enclosed for you are two copies of a letterhead memorandum dated and captioned as above.  
Very truly yours,  
John Edgar Hoover  
Director

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked ar item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 4 2 6 9	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR	
GAETANO <sup>FIRST</sup> <sup>MIDDLE</sup> PHILIPPO IMPERATORE, SR. Guy PHILLIP Imperatore, Sr.				06-30-79 3:40 P.M.	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS
MALE	CAUCASIAN	02-18-37	92 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Italy	U. S. A.		Baltimore City, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	South Balto. General		Steel Worker		RETIRED
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS
MD.			Balto		425 S. MACON ST. 21224
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
? Imperatore			CATHERINE ?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
NO		213-07-5048	MARY F. IMPERATORE 425 S. MACON ST. BALTO. 21224, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.					
IMMEDIATE CAUSE (a) <u>Bronchopneumonia &amp; Myocardial infarction</u>					
185- DUE TO, OR AS A CONSEQUENCE OF (b) <u>pulmonary edema</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of prostate, treated</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>05/23</u> 19 <u>79</u> , to <u>06/30</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>06/30</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE DEGREE				22c. DATE SIGNED	
<u>Dr. Fleischman</u>				06/30/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
M. Fleischman				South Balto. General Hosp.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		7-3-79		OAK LAWN CEM.	
23d. LOCATION CITY OR TOWN COUNTY		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
7225 EASTERN BLVD. BALTO. CO. MD.		JUL 6 1979		<u>[Signature]</u>	
24. FUNERAL DIRECTOR NAME Charles S. Zeiler 450N. Ave. 6224 EASTERN BALTO. 21224, MD.					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 4 2 7 0

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Philip Harrison INGALSBE</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 19 6 1 79		2b. HOUR M 8:31 PM
3 SEX <b>male</b>	4 RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 26, 1943</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>35</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 19 6 1 79
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>California</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Construction Foreman</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Georgia</b> 13b. COUNTY			13c. CITY OR TOWN <b>Marietta</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>2216 Favor Road 30060</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William E. Ingalsbe Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jennie E. Kees</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>253-66-9682</b>		17. INFORMANT ADDRESS <b>Powder Springs Ga.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electrocution</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: <b>9258</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOURS MONTH DAY YEAR <b>8 P.M. 6-1-79</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Came in contact with electrical wire.</b>		
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>subway tunnel</b>	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>2500 Penn. Ave. Balto. Md</b>		
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER DATE SIGNED <b>6-2-79</b>					
ACTUAL SIGNATURE <b>[Signature]</b>		EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b> ADDRESS <b>111 Penn St.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 5 1979</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Georgia Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Marietta Georgia</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 4 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

0 1 2 3 4 5 6 7 8 9

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

Report of Special Agent in Charge

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San Francisco

San Francisco

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79 14271			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William M Irby, Sr.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>June 19, 1979</b>			
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8 25 26</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10 CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>				13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Nathan Irby</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Thomas</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT ADDRESS <b>Rose Irby 1513 N. Luzerne Ave.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypotension</b> <b>4589</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Acute Renal Failure, diabetes mellitus, hypertensive</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/18/79</b> , 19 <b>79</b> , to <b>6/19/79</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/18/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Kenneth Marek</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/19/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kenneth Marek</b>				22e. ADDRESS <b>Johns Hopkins Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/23/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>	
24 FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1979</b>	
						25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 14272	
1. DECEASED NAME (TYPE OR PRINT)		FIRST James MIDDLE E. LAST Irwin, Sr.		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
James E. Irwin Sr.				6 26 79		9:45 A M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		8 29 20		58 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Baltimore City Hospitals		Oper. Engineer		Local 37	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS			
John Joshua Irwin		Betty Bennett		1851 Marshall Road			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes		WW II		214-12-8733		Mildred Irwin 1851 Marshall Rd. Baltimore 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u> 4413 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ruptured abdominal aortic aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypertension</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
6/26/79		Ruptured abd aortic aneurysm		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/26</u> 19 <u>79</u> to <u>6/26</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/26</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Kirk Kanten MD						6/26/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
KIRK KANTEN		Baltimore City Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		6/30/79		Holly Hill Mem.		White Marsh, Balto. MD	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue, Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				JUN 20 1979		Ritney McBrady	

141 87

b 112 66 54 J.H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 1 4 2 7 3 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Francis E Jackson</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>June 5, 1979</b>				2b. HOUR <b>3:45pm</b>			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7/1/33</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>45</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>M.D.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY <b>FOOD</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>M.D. BALTO EASTAINT</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2607 LYNBROOK RD.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANCIS JACKSON</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LOUISE ANDERSON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>UNK</b>				16b. SOCIAL SECURITY NO. <b>219 28 7821</b>		17. INFORMANT ADDRESS <b>CHRISTINE JACKSON ABOVE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>2</b>											
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3:45 P.M. 6 5 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>-</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>June 5, 1979</b> , to <b>June 5, 1979</b> , that (I) <del>lost</del> saw the deceased alive on <b>June 5, 1979</b> , and that in <del>my</del> <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (If <del>we</del> <del>did</del> <del>did not</del> view the body after death.)											
22b. SIGNATURE <b>Nisha Chandra</b> MD				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6.5.79.</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NISHA CHANDRA. MD</b>				22e. ADDRESS <b>JOHNS HOPKINS HOSP. BALT.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/9/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>J. G. CONNELLY 300. MACE</b>				25a. DATE <b>JUN 11 1979</b>		25b. BY REGISTRAR <input type="checkbox"/> 25c. REGISTERED SIGNATURE <b>[Signature]</b>					

THE UNIVERSITY OF CHICAGO



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the funeral home 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 4 2 7 4 REG. NO.			
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LUCY JACKSON</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 23, 1979</b>			2b. HOUR <b>09:30AM</b>				
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 21 00</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>79</b>		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.							
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Maryland</b>						13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>W UNKN</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>WINNIE UNKN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>Unkn</b>		17. INFORMANT ADDRESS <b>POCAHONTAS READ SAME AS ABOVE</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4413</b> IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ruptured Abdominal Aortic Aneurysm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>5 days</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>Congestive Heart Failure, Hypertension, Renal Failure</b>													
19a. DATE OF OPERATION <b>6/18/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ruptured Abdominal Aortic Aneurysm</b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (this hospital) attended the deceased from <b>6/18</b> , 19 <b>79</b> , to <b>6/23</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/23/79</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <b>G. MAGRAM</b> DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/23/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. MAGRAM M.D.</b>				22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL, BALT. MD</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/28/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. CALVARY CEM.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>ANNE ARUNDEL CO. MD.</b>						
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barbara McCreedy</b>					



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02:00:00 1971 12 13 1971

WILMINGTON CITY

THE WILMINGTON HOSPITAL

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WILMINGTON

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 42 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #18-22a Film G53m 8/31/79										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 4 2 7 5																			
1. DECEASED NAME (TYPE OR PRINT)										20. DATE KNOWN OF DEATH										21. DATE PRONOUNCED DEAD										22. DATE KNOWN OF DEATH																			
Nathaniel Jackson										6 13 19 79										6 13 19 79										6 13 19 79																			
3. SEX Male										4. RACE Black										5. DATE OF BIRTH MONTH DAY YEAR 6 4 44										6. AGE (IN YEARS) LAST BIRTHDAY 35										7. IF UNDER 24 HRS MONTHS DAYS HOURS MIN.									
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.										11. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.																			
10. CITY OR TOWN OF DEATH Baltimore City										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																			
13a. STATE Md.										13b. COUNTY Balto.										13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13d. STREET ADDRESS 2113 E. Chase St.																			
14. FATHER'S NAME FIRST MIDDLE LAST Oliver E. Jackson										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma Jenkins										16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 219-38-6706																			
17. INFORMANT										Thelma Jenkins										ADDRESS 2113 E. Chase St.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: 485- IMMEDIATE CAUSE (a) Acute Bronchopneumonia										DUE TO, OR AS A CONSEQUENCE OF (b)										DUE TO, OR AS A CONSEQUENCE OF (c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION CITY OR TOWN COUNTY STATE																													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural Causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										TITLE (SPECIFY) Assistant MEDICAL EXAMINER										DATE SIGNED 6/14/79																													
ACTUAL SIGNATURE [Signature]										M.D. Hormez R. Guard, M.D.										ADDRESS 111 Penn St. Balto., MD.																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 6/19/79										23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.										23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.																			
24. FUNERAL DIRECTOR NAME Wm C March F/H										ADDRESS 1101 E. North Ave.										25a. DATE REC'D. BY REGISTRAR JUN 15 1979										25b. REGISTRAR'S SIGNATURE [Signature]																			

2 7 8 4 1 8 8



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (1))  
15M 7/76

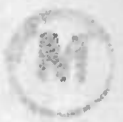
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 4 2 7 6

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
SOLOMON		S.		JACKSON				6		17		79					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
male	black	3 11 25		34 YRS.						6		20		79		12:10 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Md.		USA		WIDOWED		DIVORCED		Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		665 Dumbarton Avenue															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		665 Dumbarton Ave.									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST							
Wilbur				Jackson		Aurelia				Henry							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		215-16-2507		Marian Young		665 Dumbarton Ave.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
4292		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		M.D.		TITLE (SPECIFY)		DATE SIGNED											
Margarita A. Korell, M.D.		111 Penn Street				6/20/79											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
				Burial		6/25/79		Baltimore Cem.		Baltimore, Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Wm C March F/H		1101 E. North Ave.		JUN 26 1979		R. J. Brady											

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14210



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U.S. - 10-1000, Martin Young, 1001 D. Street, N.W.

Washington, D.C. 20001

U.S. - 10-1000, Martin Young, 1001 D. Street, N.W.  
Washington, D.C. 20001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 4 2 7 7	
FOR 1 - STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>VERNON B. JACKSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 10 1979</b>			2b. HOUR <b>5:59 AM</b>					
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 15 28</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>51</b>		8. IF UNDER 24 HRS HOURS MIN <b>59</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1810 E. Madison St.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Rudolph Coleman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susie Jackson</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-22-2110</b>		17. INFORMANT ADDRESS <b>Bertha Fairley 1816 Freedomway Nor.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>SEPTIC SHOCK</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>DRUG-INDUCED PANCYTOPEMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>OAT CELL CARCINOMA</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 HR.</b> <b>7 D.</b> <b>10 mo.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>CENTRAL NERVOUS SYSTEM METASTASES</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/5/79</b> to <b>6/10/79</b> , that (I) (we) last saw the deceased alive on <b>6/10/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If wet (and) (did not) view the body after death.											
22b. SIGNATURE <b>Charles E. Riggs, Jr.</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>6/10/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES E. RIGGS, JR</b>			22e. ADDRESS <b>22 S. GREENE ST., BALTIMORE, MD</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/15/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Nat. Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel, Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>			ADDRESS <b>1101 E. North Ave.</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

Helen

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Helen</u> LAST <u>Jacobi</u>		2a. DATE OF DEATH MONTH <u>June</u> DAY <u>6</u> YEAR <u>1979</u>		2b. HOUR <u>12:30</u> M <u>PM</u>	
3. SEX <u>F</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH <u>5</u> DAY <u>6</u> YEAR <u>1900</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>79</u> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>md</u>	7b. CITIZEN OF WHAT COUNTRY? <u>US</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore</u> MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Luthaerh</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>—</u>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>✓</u> 13b. COUNTY <u>✓</u> 13c. CITY OR TOWN <u>✓</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <u>✓</u> MIDDLE <u>✓</u> LAST <u>✓</u>			15. MOTHER'S MAIDEN NAME FIRST <u>✓</u> MIDDLE <u>✓</u> LAST <u>✓</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>9</u>		16b. SOCIAL SECURITY NO. <u>213-20-2831</u>		17. INFORMANT ADDRESS <u>✓</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio-sclerotic C-V. Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Senility</u> 4292					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 wks</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR <u>A.M.</u> MONTH <u>19</u> DAY <u>19</u> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 1st</u> 19 <u>1979</u> to <u>June 6th</u> 19 <u>1979</u> saw the deceased alive on <u>June 6th</u> 19 <u>1979</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>M. Paul Byerly</u>		DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/6/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. Paul Byerly</u>		22e. ADDRESS <u>6415 Murray Hill Rd</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>6/8/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Catharine</u>	
23d. LOCATION CITY OR TOWN <u>Bowie</u> COUNTY <u>✓</u> STATE <u>✓</u>		24. FUNERAL DIRECTOR NAME <u>✓</u> ADDRESS <u>✓</u>			
25a. DATE REC'D. BY REGISTRAR <u>JUN 11 1979</u>		25b. REGISTRAR'S SIGNATURE <u>✓</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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M. 1/2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR (MARYANNA)									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARYANNA D JANOWIAK						2a. DATE OF DEATH MONTH DAY YEAR JUNE 6, 1979		2b. HOUR 9:45PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7-14-1919		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME & HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE Md				13b. COUNTY BALTO CITY		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 805 S. PORT ST.	
14. FATHER'S NAME FIRST MIDDLE LAST John CHULDZINSKI				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARYANNA RORKOWSKI					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS G. JANOWIAK - 805 S. PORT ST			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROBABLE MESENTERIC THROMBOSIS 2384 } DUE TO, OR AS A CONSEQUENCE OF POLYCYTHEMIA VERA (b) } (c) } DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) RENAL FAILURE, BY PNEUMONIA, RIGHT LUNG									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from MAY 30, 19 79, to JUNE 6, 19 79, that (I) <input checked="" type="checkbox"/> saw the deceased alive on JUNE 6, 19 79, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If <input type="checkbox"/> did not view the body after death.)									
22b. SIGNATURE A. F. NOUR						DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-6-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. F. NOUR						22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTIMORE, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUNE 9, 79		23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.			
24. FUNERAL DIRECTOR NAME Wm. A. FIALKOWSKI						25a. DATE REC'D. BY REGISTRAR JUN 12 1979		25b. REGISTRAR'S SIGNATURE Turkey McCreedy	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14280

1. DECEASED NAME (TYPE OR PRINT) <b>SAMUEL JASLOW</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>6-27-79</b>		2b. HOUR MIN <b>3:40 AM</b>	
3. SEX <b>Male</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5-5-1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>1 22 3 40</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Rumania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Levindale Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Paper hanger</b>		12b. LINE OF BUSINESS OR INDUSTRY <b>WALL COVERINGS</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>4248 Labyrinth Road</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FANNIE UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>219-32-0725</b>		17. INFORMANT ADDRESS <b>MRS IDA JASLOW 4248 LABYRINTH RD. #21215</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>AS CVA</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (he) (this hospital) attended the deceased from <b>5/14/79</b> 19_____, to <b>6/27/79</b> 19_____, that (1) (was) last saw the deceased alive on <b>6/27/79</b> 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Joseph Berman</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/27/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH BERMAN</b>		22e. ADDRESS <b>Lincoln Hg</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JUNE 28, 1979</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LIBERTY PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>RANDALLSTOWN BALTO. MD</b>
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McBrady</b>	
6010 REISTERSTOWN RD. BALTO., MD 21215					

08-11-88

08-11-88

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
1. FOR STATE REGISTRAR		7 9		1 4 2 8 1		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
MARY L. Jefferson								6		10		79		2		PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		MONTHS		DAYS		HOURS	
Female		Black		12 12 92		86		YRS									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Va.		USA				Baltimore City											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore City		Baltimore City Hosp.															
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				2543 Calverton Hgts Ave.							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST							
										Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		217-07-1954		Dorothy Baker		2543 Calverton Hgts Ave.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Cardio-Pulmonary																	
2500 DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
b) Diabetes mellitus																	
DUE TO, OR AS A CONSEQUENCE OF																	
c) Cerebrovascular Accident																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
												YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on June 10, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																	
22b. SIGNATURE										DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
R. PAT Riley										MD				6-10-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS							
R. PAT Riley																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
Burial										6/15/79		Cedar Hill Cem.		Anne Arundel Co., Md.			
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm C March F/H										1101 E. North Ave.		JUN 12 1979					

18241 28



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR Items 19b.  
1- STATE FILM#G533 as 7-16-79  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 7 9 1 4 2 8 2  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Albennie Bennie Jenkins</b>			2a. DATE OF DEATH MONTH <b>6</b> DAY <b>18</b> YEAR <b>79</b>			2b. HOUR <b>11:17 PM</b>								
3. SEX <b>F</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH MONTH <b>3</b> DAY <b>8</b> YEAR <b>05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.								
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LUTHERAN HOSP.</b>				12a. USUAL OCCUPATION (STATE OF WORK FOR MOST OF WORKING LIFE) <b>Barber</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>594 HANNAH TOWN RD</b>		
14. FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b>Garrett</b> LAST <b>Garrett</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Wesley</b> MIDDLE <b>Wesley</b> LAST <b>Wesley</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO <b>216-26-3779-A</b>		17. INFORMANT ADDRESS <b>SUSANINE MACOY 2121 WINGERS</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory failure &amp; hypertension</b> 7854 DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sepsis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a. DATE OF OPERATION <b>5/16/79</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gangrene cellulitis of left leg</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <b>4/19</b> , 19 <b>79</b> , to <b>6/18/79</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/18/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>Young J. You</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Young J. You</b>						22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6-25-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>						
24. FUNERAL DIRECTOR NAME <b>Mr D Hayes 638 E. Calmar St</b>						25. DATE REC'D BY REGISTRAR <b>JUN 21 1979</b>			26. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

1944



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 4 2 8 3

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		MONTH		DAY	YEAR	2b. HOUR
James A. Jennifer III					XX		6	17	19	79	M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR
Male	Black	2 7 79		4	4				6 17 19 79		12:05
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Baltimore		USA		WIDOWED		DIVORCED		Baltimore City		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore City		Provident Hospital									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4126 Fairview Ave.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
JAMES				JENNIFER III SR.				ANDRIA McCUTHEON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
N/A		N/A		N/A		Katherine Jennifer 4110 Alto Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Thermal burns											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) Immersion											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
5 P.M. 6/16/19 79				6/16/19 79		Subject immersed in hot water					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
home				home		4126 Fairview Ave.		Baltimore		Maryland	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Virginia L. Dolan				M.D. Assistant				6/18/79			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Virginia L. Dolan, M.D.				111 Penn St. Balto., MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
Burial		5/22/79		Mt. Calvary Cem.		Baltimore				Md.	
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm. C. March F/H, 1101 E. North Ave.						JUN 22 1979		[Signature]			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. PAGES 1 AND 2 SHOULD BE FILED WITH THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



Item 8 g553 7/10/79 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

1 4 2 8 4

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Norman W Jeromin</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 19, 1979</b>			2b. HOUR <b>5:10A</b>				
3 SEX <b>M</b>		4 RACE <b>W</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>7 18 54</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>44</b> YRS.		7 UNDER 1 YEAR MONTHS DAYS <b>44</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10 CITY OR TOWN OF DEATH <b>BALTO. CITY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NATIONAL CAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO CITY</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>532 4011Y HUNT RD.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>BENJAMIN JEROMIN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>AMELIA GIELNER</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-30-1291</b>		17 INFORMANT ADDRESS <b>HELEN JEROMIN ABOVE</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION AND CARDIOGENIC SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>S/P OPEN HEART SURGERY</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 min</b> <b>3 days</b> <b>5 days</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION <b>6/13/79</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CORONARY ARTERY DISEASE</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (his hospital) attended the deceased from <b>6/13</b> , 19 <b>79</b> , to <b>6/19</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/19</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Karl J. Karlson, MD</b>						DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/19/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KARL J. KARLSON, MD</b>						22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>6/21/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>DUNDALK BALTO. MD.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>CONNELLY F.H. 300 MACE AVE.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Hickey McCreedy</b>		

MEDICAL CERTIFICATION

TO HOSPITALS ATTENDING PHYSICIANS: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital for its records.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
JUANITA		A.		JERSCHIED	6/13/79				5A M
3 SEX	4 RACE	5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Female	Caucasian	June 2, 1918			61		MONTHS DAYS		HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	U.S.A.				Baltimore City MD				
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
Balto.	Balto. City Hosp.				Cashier		--		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland		-		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5606 Denwood Avenue		
14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Myron G. Jones					Maude				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS		
No					213-01-1487		Chas. H. Jerscheid, Jr. 3811 Gough St. 21224		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>									
4275									
DUE TO, OR AS A CONSEQUENCE OF									
(b) _____									
DUE TO, OR AS A CONSEQUENCE OF									
(c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a: I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b SIGNATURE					DEGREE			22c. DATE SIGNED	
G. Weiner M.D.								6/13	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e ADDRESS				
G. Weiner M.D.					Balto City Hosp.				
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		6/16/79		Baltimore Cemetery		Baltimore, Md.			
24. FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
St. Ann's Funeral Home, Inc.		3331 Brehms Lane Balto. Md. 21213		JUN 15 1979		[Signature]			



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14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										9 1 4 2 8 6		
1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH								REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
Lillian W. Jewell						6 21 79			9:40 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		Aug. 26, 1919		59 years		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
New Jersey		U.S.A.				BALTIMORE CITY MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE		ST AGNES HOSPITAL						Homemaker				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.			Baltimore		Arbutus		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5516 Selma Avenue 21227			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			ADDRESS						
FIRST MIDDLE LAST			FIRST MIDDLE LAST			Road, Pasadena, Md 21227						
Raymond Nelson			Elizabeth Whildin									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
NO			155-10-9490		Mr. William H. Jewell, Jr. 136 Bar Harbor							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Cardio-respiratory arrest												
496- DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe obstructive lung disease												
DUE TO, OR AS A CONSEQUENCE OF (c) Acute Myocardial Infarction												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 6/20/79 to 6/21/79, that (I) (we) last saw the deceased alive on 6/21/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not) view the body after death.												
22b. SIGNATURE			DEGREE						22c. DATE SIGNED			
Prasade Vankineni MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						6/21/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
P. VANKINENI			900 Caton Ave Baltimore - MD - 21229									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial			6/23/79		Loudon Park Cemetery		Baltimore City, Maryland					
24. FUNERAL DIRECTOR NAME			ADDRESS		DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Hubbard Funeral Home, Inc.			4107 Wilkens Ave.		JUN 22 1979		[Signature]					

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ATLANTA CITY

BY ORDER OF THE

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Atlanta City

TO HOSPITAL OR ATTENDING PHYSICIAN: The certificate is to be retained by the hospital or attending physician. It is to be returned to the funeral home or to the funeral director. After this certificate has been signed by the attending physician and completed and filed in by the funeral home or the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 91 14287			
1- FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bernice Johnson				June 26, 1979 11:05 a.m.			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 4 04		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Johns Hopkins Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Md.		13b. COUNTY Balto.		13c. STREET ADDRESS 2236 Penna. Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Phillip W. Harcum				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Jackson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Phillip W. Harcum 2236 Penna. Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aeromonas septicemia 2000 DUE TO, OR AS A CONSEQUENCE OF (b) Diffuse histiocytic lymphoma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 9 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Gastrointestinal Bleeding.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from June 9, 1979, to June 26, 1979, that (2) (we) lost saw the deceased alive on June 26, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)							
22b. SIGNATURE Charles G. Helmick III MD				DEGREE MD		22c. DATE SIGNED June 26, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Helmick				22e. ADDRESS 4940 Eastern Ave. Balt 21224			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/30/79		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 29 1979	
				25b. REGISTRAR'S SIGNATURE Rusty McCreedy			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14288

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Cornelius Johnson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6/5/79</b>		2b. HOUR MIN. <b>6:55 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>Negroid</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10-5-19 04</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>city</b>			10. CITY OR TOWN OF DEATH <b>Balto.</b>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Balto. City Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Cornelius Johnson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hattie</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>216-05-4447</b>		17. INFORMANT ADDRESS <b>Cornelius Johnson 2214 Elsinor Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4275 Cardio-pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>June 8, 19 79</b> to <b>June 5, 19 79</b> , that (I) (we) last saw the deceased alive on <b>June 5, 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.						
22b. SIGNATURE <b>Walfredo J. Leon MD</b>				22c. DATE SIGNED <b>6/5/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALFREDO J. LEON</b>				22e. ADDRESS <b>Baltimore City Hospital</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-8-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Cem.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>						
24. FUNERAL DIRECTOR ADDRESS <b>Vernon Bailey F.H. 1348 Calhoun St.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 7 1979</b>		
				25b. REGISTRAR'S SIGNATURE <b>Henry McBrady</b>		

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OFFICE OF THE  
SPECIAL AGENT



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 4 2 8 9

1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 6 DAY 20 YEAR 1979										2b. HOUR 2:10	
1. DECEASED NAME (TYPE OR PRINT) GERALDINE JOHNSON										2c. DATE PRONOUNCED DEAD MONTH 6 DAY 20 YEAR 1979										2d. HOUR A	
3. SEX female		4. RACE black		5. DATE OF BIRTH MONTH 2 DAY 7 YEAR 1979		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Gloucester VA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City									
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 1110 Warwick Avenue								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland										13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1110 Warwick Ave. Apt. 204					
14. FATHER'S NAME William										15. MOTHER'S MAIDEN NAME Liana Bantley		16. SOCIAL SECURITY NO. 219-18-8633									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 219-18-8633		17. INFORMANT Denise Connor 5511 Wilex Ave.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease 4-292 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																					
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 6/20/79									
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6-20-79		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.				23d. LOCATION Arbutus				COUNTY MD.							
24. FUNERAL DIRECTOR William J. Spicer				ADDRESS 1639 N. Broadway				25a. DATE REC'D. BY REGISTRAR JUN 25 1979				25b. REGISTRAR'S SIGNATURE									

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
LEWIS J. JOHNSON JR.		6 14 79		12:16 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
M	B	1 28 18	61 YRS	MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
BALT. MD.	US		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
BALT. MD.	MERCY HOSPITAL	Retired postal	post office		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	-	BALT	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2203 Windsor Ave	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
LEWIS J. JOHNSON SR.		MARY ETHEL BENNETT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		219-01-8501		Lillie F. Johnson 2303 Windsor Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary edema</u> DUE TO, OR AS, A CONSEQUENCE OF (b) <u>hypoproteinemia</u> DUE TO, OR AS, A CONSEQUENCE OF (c) <u>embolus of the liver</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>6 months</u> <u>5 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>alcoholism</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>May 14, 1979</u> to <u>June 14, 1979</u> , that (1) (we) last saw the deceased alive on <u>June 14, 1979</u> , and that (1) (we) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Stuart Jacobs MD</u>		22c. DATE SIGNED <u>6-15-79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JACOBS</u>		22e. ADDRESS <u>301 St Paul Pl. Balt, Md- 21202</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		6/20/79		Md. Nat. Mem. Pk.	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR			
Laurel, Md.		JUN 20 1979			
24. FUNERAL DIRECTOR NAME ADDRESS		25. REGISTRAR'S SIGNATURE			
Wm C March F/H 1101 E. North Ave.		<u>[Signature]</u>			

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*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE																					
1 - FOR STATE REGISTRAR			7 9 1 4 2 9 1 REG. NO.																		
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Lillian</i>		MIDDLE <i>J.</i>		LAST <i>Johnson</i>		2a. DATE OF DEATH		MONTH <i>June</i>		DAY <i>29</i>		YEAR <i>1979</i>		2b. HOUR <i>805A</i>				
3. SEX <i>Female</i>			4. RACE <i>white</i>		5. DATE OF BIRTH MONTH <i>Feb</i> DAY <i>23</i> YEAR <i>1900</i>				6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>W. Virginia</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.													
10. CITY OR TOWN OF DEATH <i>Baltimore</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Home in the Pines Bel.</i>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>- -</i>					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE <i>Md.</i>		13b. COUNTY		13c. CITY OR TOWN <i>Balta.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>211 N. Lorraine 21211</i>			
14. FATHER'S NAME FIRST <i>Dempsey</i> MIDDLE <i>Jackson</i> LAST					15. MOTHER'S MAIDEN NAME FIRST <i>Unknown</i> MIDDLE <i>Unknown</i> LAST																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>- -</i>			17. INFORMANT <i>Mr. Herman L. Johnson, Jr.</i>			ADDRESS <i>806 W. 35th St</i>												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>ASCVD</i> <i>4292</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>CVA</i>																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <i>JUL 29</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>29 June</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, I did not view the body after death.)																					
22b. SIGNATURE <i>Alleby</i> DEGREE										22c. DATE SIGNED <i>6/29/79</i>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Arneson MD</i>										22e. ADDRESS <i>3610 PERRY AVE BALD MD 21215</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>7/2/79</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Lake View Mem. Pk.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Ykessville, Carroll Co, M.</i>												
24. FUNERAL DIRECTOR NAME <i>A. Alan Seitz</i> ADDRESS <i>Funeral Home 3818 Roland Ave.</i>										25a. DATE REC'D. BY REGISTRAR <i>JUL 2 1979</i>		25b. REGISTRAR'S SIGNATURE <i>History Academy</i>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director or with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 9 1 4 2 9 2							
1. DECEASED NAME (TYPE OR PRINT) <b>NEZZIE Johnson</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6-26-79</b>			2b. HOUR <b>8:52 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 25 95</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3827 Payton Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unkn</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unkn</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>248-74-8722</b>		17. INFORMANT ADDRESS <b>Gertrude Edwards 3827 Rayton Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pulmonary, cardiac &amp; renal failure</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Ovarian cyst</b>									
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <b>Edward O. Hunt Jr MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6/26/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD O. HUNT Jr MD</b>				22e. ADDRESS <b>2300 GARRISON BLVD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/1/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Darlington Cty., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Lillian McLeod</b>	

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STREET & AVENUE



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(11)

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STREET & AVENUE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 9 14293						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Reginald G. Johnson</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>6 6 79</b>		2b. HOUR <b>M</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 15 15</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>64</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>501 Dolphin Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>						13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Garney Fittman</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mae Johnson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-01-5612</b>		17. INFORMANT <b>Edna Johnson</b>		ADDRESS <b>501 Dolphin St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2500</b> <b>apparent ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF, (b) <b>Diabetes &amp; old age</b> DUE TO, OR AS A CONSEQUENCE OF, (c) <b>2500</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>Catheter s/p resection and radiation</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <b>J P BURDICE</b>				DEGREE <b>ATTENDING PHYSICIAN</b>		22c. DATE SIGNED <b>6/6/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J P BURDICE</b>				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/9/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry Holmberg</b>	

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14294

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Sarah P. Johnson</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 25 1979</b>			2b. HOUR <b>3:55 P.</b>			
3. SEX <b>female</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 27 15</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>64 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 27 1979</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Philadelphia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3719 Columbus Drive</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Pub. School</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3719 Columbus Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Oscar Johnson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hattie Peaco</b>			16. ADDRESS <b>1425 Florence Ave. Miss.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>214-40-4567</b>		17. INFORMANT <b>Mr. Raymond I Johnson</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> <b>4029</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 to:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Hormez R. Guard, M.D.</b>			TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>6/28/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>			ADDRESS <b>111 Penn Street, Baltimore, MD 21201</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 3, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Herbert E. Nutter</b>				ADDRESS <b>3035 W. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 6 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Robert R. Brady</i>	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

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REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Thomas Johnson Jr</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 7, 1979</b>			2b. HOUR M				
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>08 1 1923</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>55</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>SEPARATED</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD				
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1004 Reveryd Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cook</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Resturant</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>1230 Md.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1230 Druid Hill Ave.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Johnson Sr.</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie L. McIntoch</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>217-14-2658</b>		17 INFORMANT ADDRESS <b>Mr. Pickett Johnson 2423 W. Mosher</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPIRATION</b> <b>1490</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CARCINOMA OF THE PHARYNX</b> DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>4/1/79</b> to <b>6/7/79</b> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated										
22b. SIGNATURE <b>Keith Mitchell MD.</b>						DEGREE <b>MD.</b>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KEITH E. J. MITCHELL</b>						22e. ADDRESS <b>1230 Druid Hill Ave.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>June Burial</b>			23b. DATE <b>June 12, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Herbert E. Nutter</b>						ADDRESS <b>3035 W. North Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 11 1979</b>		
						25b. REGISTRAR'S SIGNATURE <b>Anthony Kennedy</b>				

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14296	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Willie E. Johnson						2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 3 1979		2b. HOUR M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 9 57		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 21		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 3 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore City				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Luthern Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.						13b. COUNTY Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1600 W. Lafayette Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Joe B. Johnson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mozella Hill					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215-78-6916		17. INFORMANT ADDRESS Mozella Johnson 1600 W. Lafayette Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of abdomen</u> 9654 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 10:30 6 2 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot by assailant					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1600 Blk. Lavrens St. Balto. MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Thomas D. Smith, M.D.						TITLE (SPECIFY) Deputy Chief				DATE SIGNED 6/4/79	
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.						ADDRESS 111 Penn St. Balto., MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/8/79		23c. NAME OF CEMETERY OR CREMATORY King Memorial Pk.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H						ADDRESS 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR JUN 5 1979	
						25b. REGISTRAR'S SIGNATURE Rickey H. Brady					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
AMELIA L. JONES					June 19, 1979	8:55 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Female	White	12 August 1911		67 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
West Virginia	U.S.A.			BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	UNION MEMORIAL HOSPITAL		Glass Inspector		Glass Factory	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS	
Maryland		Frederick	Thurmont		314 West Main Street	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
John LIPPOLD		Theresa MALETICH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Mrs Margaret Grant (Sister), 928 Kent Ave., Baltimore, Md. 21228		
No		217-10-4328				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>Cavernous</u> (b) <u>ruptured Carotid Artery</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>12 hrs.</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1976 pt. had fall that resulted in development of cavernous carotid						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:00 P.M. 6 18 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) fall		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 314 W. Main St. Thurmont Md.		
22. I certify that (I) (this hospital) attended the deceased from 6/18, 1979, to 6/19, 1979, that (I) (we) lost saw the deceased alive on 6/19, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. accident						
22b. SIGNATURE Paul Gertler		22c. DATE SIGNED 6/19/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL GERTLER		22e. ADDRESS UNION MEMORIAL HOSPITAL, Baltimore, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		6/22/79	St. Mary's Cemetery		Cumberland, Maryland	
24. FUNERAL DIRECTOR NAME Charles Wm. Miller, Funeral Home, 104 East Main Street, Thurmont, Maryland				25a. DATE REC'D. BY REGISTRAR JUN 26 1979		25b. REGISTRAR'S SIGNATURE Hofrey McCready

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
<div style="text-align: center;"> <div>FOR 1 - STATE REGISTRAR</div> <div>7 9 1 4 2 9 8</div> <div>CERTIFICATE OF DEATH</div> </div>										
1. DECEASED NAME (TYPE OR PRINT) CLEVELAND JONES					2a. DATE OF DEATH MONTH DAY YEAR JUNE 29 1979					2b. HOUR 1:05 AM
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 16 16		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montebello Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST Glover Jones					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mable Green					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 230-22-7143		17. INFORMANT Eula J. Bell		ADDRESS Rich. Va. 247 Loburneer Hght				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> <u>1991</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Adeno CARCINOMA OF BONE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>3 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <u>SHAHID SAEED</u> (this hospital) attended the deceased from <u>5-23-1979</u> , to <u>6-29-1979</u> , that (I) (we) lost saw the deceased alive on <u>6-29-1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Shahid Saeed</u> M.D.					DEGREE M.D.			22c. DATE SIGNED 6-29-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHAHID SAEED					22e. ADDRESS 199 LIONHEAD CT. BART, MD. 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/2/79		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.				
24. FUNERAL DIRECTOR NAME Wm C March F/H					ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUL 2 1979		25b. REGISTRAR'S SIGNATURE <u>Shirley McBrady</u>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>James A. Jones, Jr.</b>		2a. DATE OF DEATH MONTH <b>6</b> DAY <b>29</b> YEAR <b>79</b>		2b. HOUR <b>M</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>12</b> YEAR <b>30</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.
10. CITY OR TOWN OF DEATH <b>Balto.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3705 W. Belvedere Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>Md.</b>		13b. COUNTY	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>A.</b> LAST <b>Jones, Jr.</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Evelyn</b> MIDDLE <b>Truitt</b> LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>Korean</b>		17. INFORMANT <b>Peggie Jones</b>
		ADDRESS <b>3705 W. Belvedere Ave.</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>METASTASES FROM</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SQUAMOUS CELL</b> (c) <b>CARCINOMA OF LUNG</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Roger Theodore</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROGER THEODORE</b>		22e. ADDRESS <b>711 West 40th STREET BALTIMORE MD</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>7/3/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Wesley Meth. Ch.</b>		23d. LOCATION CITY OR TOWN <b>Snowhill, Md.</b> COUNTY <b>21211</b> STATE
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>		ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 2 1979</b>
		25b. REGISTRAR'S SIGNATURE <b>Patricia Mabrey</b>		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 1 4 3 0 0 REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) John R Jones				2a. DATE OF DEATH MONTH DAY YEAR 6-11-79				2b. HOUR 6:35 A.M.			
3. SEX Male		4 RACE Negroid		5. DATE OF BIRTH MONTH DAY YEAR Feb. 9, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital of Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Business			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1810 East LaFayette Ave			
14 FATHER'S NAME FIRST MIDDLE LAST Paul Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Burton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-10-5755		17. INFORMANT Charles Vernon Jones				ADDRESS 1810 East LaFayette Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE RENAL FAILURE</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBRO VASCULAR ACCIDENT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-31-1979</u> to <u>6-11-1979</u> , that (I) (we) last saw the deceased alive on <u>June 10</u> 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Baskaran				DEGREE M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-11-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMBANDAM BASKARAN				22e. ADDRESS Lutheran Hospital Balto. Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-14-79		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis County Maryland		25a. DATE REC'D. BY REGISTRAR JUN 12 1979			
24. FUNERAL DIRECTOR NAME Calvin B. Scruggs Sr.				ADDRESS 1412 E. Preston St.				25b. REGISTRAR'S SIGNATURE L. J. H. H. H.			

U O L A I R

1892

2562-2564

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LEO LEO JONES JONES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-29-79 6-29-79 3:25 PM</b>		
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2-29-11</b>	6. AGE (IN YEARS, LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY.</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CHURCH HOME CORP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED.</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>BALTO.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>201 N. BROADWAY APT 90</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN JONES</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>PORENE VANLANDINGHAM 3225 MIDDLE ST</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MEDIASTINAL TUMOR</b> <b>2398</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SEVERAL MONTHS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6-11-79</b> to <b>6-29-79</b> , that (I) (we) lost saw the deceased alive on <b>6-29-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>A. J. Helou</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6-29-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. A. J. HELOU M.D.</b>		22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>7/3/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>H.A. County Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Locks FUNERAL HOME</b>		ADDRESS <b>1304 N. Central</b>		25. DATE REC'D. BY REGISTRAR <b>JUL 2 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED

10001	22	11-8-11	11-8-11	11-8-11	11-8-11
10001	22	11-8-11	11-8-11	11-8-11	11-8-11
10001	22	11-8-11	11-8-11	11-8-11	11-8-11
10001	22	11-8-11	11-8-11	11-8-11	11-8-11
10001	22	11-8-11	11-8-11	11-8-11	11-8-11
10001	22	11-8-11	11-8-11	11-8-11	11-8-11
10001	22	11-8-11	11-8-11	11-8-11	11-8-11
10001	22	11-8-11	11-8-11	11-8-11	11-8-11
10001	22	11-8-11	11-8-11	11-8-11	11-8-11
10001	22	11-8-11	11-8-11	11-8-11	11-8-11

10001

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RELEASED ON APPROVAL BY DR DOLAN MEDICAL EXAMINER

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					3 187 52 40 9 JUNE 14 3 0 2 0 REG. NO. 46				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mae P Jones</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>June 14, 1979</b>			2b. HOUR <b>6:31pm</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 15 1946</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>34</b>		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Harford</b> 13c. CITY OR TOWN <b>SALISBURY</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>UPPER FERRY RD GEN DEL.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>TAFTY FLEMING</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Brandt PHYLLIS UNK.</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) <b>0</b>					16b. SOCIAL SECURITY NO. <b>247-84429</b>		17. INFORMANT ADDRESS <b>Herbert Jones, upper F Road</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiogenic/Hypovolemic Shock</b> <b>396-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>AVR/MVR, Cardiotomy on Heart Rungs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>AI/MR</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 Hours</b> <b>8 Hours</b> <b>1 1/2 - 2 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>6/14/79</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>AI/MR POSSIBLE TRICUSPID Regurg</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6:31 PM 6 14 1979</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <input checked="" type="checkbox"/> this hospital attended the deceased from <b>JUNE 10</b> , 19 <b>79</b> , to <b>JUNE 14</b> , 19 <b>79</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>JUNE 14</b> , 19 <b>79</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death									
22b. SIGNATURE <b>Christopher S. McCullough MD</b>						DEGREE <b>MD</b>		DATE SIGNED <b>6/14/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHRISTOPHER S. MCCULLOUGH</b>						ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6-22-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Reverend Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Reverend Cemetery MD</b>		
24. FUNERAL DIRECTOR NAME <b>Archie James, 407 Somerset Ave</b>						ADDRESS <b>Pe Anne</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>	
						25b. REGISTRAR'S SIGNATURE <b>Archie James</b>			



14002

Jones

Lee

The Johns Hopkins Hospital

Baltimore

RECEIVED BY MAIL ROOM OF THE NATIONAL ARCHIVES

4-20-64

THIS IS A COPY



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR			7 9			1 4 3 0 3 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE JONES LAST JONES						2a. DATE OF DEATH MONTH DAY YEAR 6 25 79		2b. HOUR M		
3. SEX FEMALE		4. RACE NEGROID		5. DATE OF BIRTH MONTH DAY YEAR 1-7-1903		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.				
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1414 W. LAFAYETTE AVE.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1414 W. LAFAYETTE AVE.	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS JONES					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARA JACKSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS SARA JONES 1414 W. LAFAYETTE AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Cardio Vascular disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 MIN 4 YEARS 4 YEARS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Arterio Sclerosis										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (i) this hospital attended the deceased from APRIL 3, 1975, to MARCH 30, 1979, that (ii) (we) last saw the deceased alive on MARCH 30, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Samuel R. Owings, Jr., M.D.						22c. DATE SIGNED 6-26-79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Samuel R. Owings, Jr., M.D.		
22e. ADDRESS 909 N. Carey Street 21217										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6-30-79		23c. NAME OF CEMETERY OR CREMATORY ARABUS MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. Md.			
24. FUNERAL DIRECTOR NAME VERNON BAILEY						25a. DATE REC'D. BY REGISTRAR JUN 27 1979		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 4 3 0 4

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>MARY E. JONES</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 14 1979</b>		2b. HOUR <b>10:40P M</b>	
3 SEX <b>FEMALE</b>	4 RACE <b>NEGRO</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>6 22 1902</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MARYLAND GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MARYLAND</b>		13b. COUNTY	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES ANDERSON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MATTIE JONES</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-18-5652</b>		17. INFORMANT ADDRESS <b>DORIS CONLEY 86 Summerfield Dr. Annapolis, Md.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METABOLIC ACIDOSIS</b> 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>RENAL FAILURE</b> (c) <b>METASTATIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>JUNE 6 1979</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RUPTURED ABDOMINAL VISCERA</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JUNE 6 1979</b> to <b>JUNE 14 1979</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>JUNE 14 1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (XXX) view the body after death.					
22b. SIGNATURE <i>Krikor Tatoyan</i>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6-15-79</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Krikor Tatoyan M. D.</b>		22e. ADDRESS <b>c/o Maryland General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6-19-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PINELAWN MEM. PARK</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis Maryland</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JUN 20 1979</b> <i>Anthony McBrady</i>			
24. FUNERAL DIRECTOR NAME <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>		ADDRESS <b>Annapolis, Md.</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL SUPERINTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital and the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Thereafter, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 14305							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUFUS H JONES			2a. DATE OF DEATH MONTH DAY YEAR JUNE 22, 1979			2b. HOUR 2:03A M			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 9-26-25		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANICAL ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10135 SPRING POOLS LANE	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Drewery		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W.II 219-22-1793		17. INFORMANT ADDRESS Mrs. Lorraine Jones 10135 Spring Pools Lane Columbia, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Upper airway Obstruction, Resp Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Oat cell carcinoma, lung DUE TO, OR AS A CONSEQUENCE OF (c) 9 mos. 1629									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None									
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6/22 1979 to 6/22 1979, that (I) (was) lost saw the deceased alive on 6/22 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE Michael S. Lux		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/22/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael S. LUX, M.D.		22e. ADDRESS Johns Hopkins Hosp.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-27-79		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Randolph J. Collick		ADDRESS 24316 Oliver St.		25a. DATE REC'D. BY REGISTRAR JUN 27 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15  
FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH JONTIFF</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 22, 1979</b>		2b. HOUR <b>9:51 A.M.</b>	
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH <b>DEC. 25, 1896</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b>			
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>INVESTOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>REAL ESTATE</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>BALTIMORE</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>ABRAHAM JONTIFF</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DORA EZERSKY</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-16-7559</b>		17. INFORMANT <b>MRS. LILLIAN JONTIFF</b> <b>6810 PARK HTS. AVE., APT. 303 #21215</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1975</b> , to <b>June 1979</b> , that (I) (we) lost saw the deceased alive on <b>June 18 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Marc Mugmon MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6-22-79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARC MUGMON</b>				22e. ADDRESS <b>201 E. UNIV. PKWY BALT MD</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JUNE 24, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH TFILOH</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>
24 FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 9 14307							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>IRENE E. JOYCE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 27 '79</b>			2b. HOUR <b>7<sup>50</sup> P.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 12 97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Balto. City Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>633 N. Aisquitith</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas H. Greene</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary E.</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-22-0203</b>		17. INFORMANT ADDRESS <b>Samuel Floyd 1216 Winston Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> <b>428D</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>EMPHYSEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>CONGESTIVE HEART FAILURE</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>6/15/79</b> , 19 <b>79</b> , to <b>6/25</b> , 19 <b>79</b> , that (1) (we) lost saw the deceased alive on <b>6/27/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Debra Wertheimer MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>6/27/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DEBRA WERTHEIMER</b>				22e. ADDRESS <b>BALTIMORE CITY HOSPITALS</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/2/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Co., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreary</b>	

MEDICAL CERTIFICATION

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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1. DECEASED NAME (TYPE OR PRINT) EVA May JUMP			2a. DATE OF DEATH MONTH DAY YEAR 6 24 79			2b. HOUR 12 <sup>45</sup> AM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 28, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3205 Overland Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas George Mairs				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora MacWilliams							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-10-6948		17. INFORMANT Maybelle J. Moffett		ADDRESS Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> 410 - DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 3 weeks											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypertension, Polyarthrosis</u>											
19a. DATE OF OPERATION <u>6/20</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/20</u> , 19 <u>79</u> , to <u>6/24</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/24</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>R Gold</u>		DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>6/24/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>R Gold</u>				22e. ADDRESS <u>Union Memorial Hosp Labort +33rd St</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 27, 1979		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION CITY OR TOWN Woodlawn, Balto., Md.		COUNTY STATE			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. ADDRESS 6500 York Rd. Balto., Md.				25a. DATE REC'D. BY REGISTRAR JUN 28 1979		25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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